Metonymy and pragmatic inferencing in mental health

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CERTIFICATE OF ORIGINAL AUTHORSHIP

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

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This thesis is dedicated to people who live with mental illness, and the memory of those who went before, with respect for their courage, humour and grace.

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ABSTRACT

Language plays a key role in the assessment, diagnosis and treatment of mental illness. Pragmatically, how language functions in mental health care is heavily dependent on inferences that are drawn, both by the people experiencing mental illness, and by the clinicians assisting them. Metonymy is a language practice where one term, the source, is used to stand for another, the target, which is closely related to it conceptually. The use of a diagnostic category to refer to a person, for example, a schizophrenic, is a metonymic transfer of meaning. Metonymy occurs in everyday language and in clinical settings, and contributes to how inferences are drawn. It functions because it draws attention to a specific feature with minimal cognitive expenditure. Metonymy contributes to effective communication in contexts where the language-using group share understanding of what is deemed to be salient, and where economy of speech is valued. Nursing provides such a context. Though the intended meaning of a metonymic reference may be understood in any communication, there is the potential for attributes of the source term to carry over into the interpretation of the target meaning and lead to unintended inferences. In the mental health context, metonymy can be associated with negative outcomes in relation to labelling and the experience of stigma. Strategies have been implemented to modify language to reduce the influence of this labelling, but to date, they have not made use of the insights of cognitive linguistics.

This study is an investigation of the influence of metonymic language on the experience of people who live with mental illness. The study draws on nineteen interviews with ten participants with lived experience of psychosis. Interviews were conducted using a biographical narrative method and analysed thematically, to elicit participants’ experiences of language. Their language was also analysed for cognitive and clinical linguistic features. Participants reported experiencing language used about them in ways that foregrounded their diagnoses, including stigmatising language. They also reported experiences when they felt that legitimate concerns or requests they expressed were disregarded because of the foregrounding of their diagnoses. Participants described the beneficial effect they experienced when mental health workers used language that maintained the person’s identity separate from the illness. Metonymy and pragmatic inferencing underpin the experiences of language reported by people who live with mental illness, with both positive and negative effects. Closer attention to the influence of language can contribute to better therapeutic outcomes.

CHAPTER 1: INTRODUCTION

I began the present study as an interrogation of my own clinical practice. I had been working for several years as a mental health nurse in the public healthcare system. To augment my nursing knowledge, I had studied a counselling approach termed Narrative Therapy, and completed two workshops with Michael White, one of the originators of the approach. I integrated the approach into my clinical work with people who were experiencing a range of mental health problems, and I had the sense it was working. I had also formerly studied literature, and maintained an interest in linguistics. I was struck by common features between the concept of metonymy advanced within cognitive linguistics, and a particular strategy within Narrative Therapy, called externalising the problem, and I began to bring this analytic framework into my clinical work.

My work role changed, and so did the study. I decided that before I could suggest changes to clinical practice, it was important to clearly demonstrate that the ideas I was pursuing had merit outside my head. So I set about investigating what people with lived experience of mental illness thought. At the same time as I was interested in their stated ideas, I also wanted to analyse their language using tools from a cognitive linguistic framework, in order to see if I could identify patterns that may contribute to deeper understanding of the influence of language patterns.

Language is central to mental health practice and psychiatry. It underpins processes of assessment, diagnosis, treatment and evaluation. It can influence therapeutic engagement. At a minimum, it affects the way that people who experience mental health problems can communicate these to others, and in many cases it is integrally linked to the experiences themselves. Both ‘everyday’ language, and the particular language that occurs in mental health practice, depend heavily on people making inferences, that is, choosing and interpreting words to create shared meaning.

This study is an exploration of the influence of metonymic pragmatic inferencing on language used by and about people who live with mental illness. It uses knowledge developed in cognitive linguistics to do this.

Key terms

At the outset, I will introduce a few key terms, to clarify how they will be used in the study, and give the reader a foothold:

Metonymy is a language practice where one term is used to stand for another that is closely related to it conceptually.

Cognitive linguistics is an approach to the study of language as ‘an instrument for organising, processing and conveying information’ (Geeraerts 2008, p. 3).

Pragmatics is the study of language in use.

Inferences are conclusions drawn from cues. They ‘are based on knowledge, previous experience, expectations and needs’ (Stein-Parbury 2014, p. 196).

Aim and Objectives of the study

The aim of this study was to explore the influence of metonymic language on the experience of people who live with mental illness, including their experience of treatment.

This was achieved by the following objectives:

1. identifying metonymic practices in the clinical language that people who live with mental illness encounter and use themselves
2. exploring the significance of identity for people who live with mental illness, including the influence of diagnosis
3. identifying metonymic language in the speech production and comprehension of people who live with mental illness
4. assessing if these elements influence their experience of communication with others, including clinicians.

Research questions

The study had two research questions:

> How does the use of metonymic language influence the experience of people who live with mental illness?
>
> How does metonymy influence the speech production and speech comprehension of people who live with mental illness?

Background

LANGUAGE AND MENTAL ILLNESS

Language plays a central role in mental health practice. Clinical observation of the language of people who consult mental health services is key to assessing the problems they are experiencing (Andreasen & Grove 1986). This observation includes both language production and language comprehension. Within language production, both the content of what people say, and the form in which they say it are considered, as difficulties with each aspect contributing to understanding the problem and formulating plans for response.

The bulk of research on language and mental illness has concentrated on schizophrenia. The current textbook description of schizophrenia characterises the illness as comprising three dimensions: positive symptoms such as hallucinations and delusions, negative symptoms, such as avolition and anhedonia, and disorganisation (Lewis, Escalona & Keith 2009). The *Diagnostic and Statistical Manual of Mental Disorders DSM5* lists 'disorganized speech' as one of the three core diagnostic criteria for schizophrenia (along with delusions and hallucinations) (American Psychiatric Association 2013, p. 99). Observations of language use contribute to the diagnosis of other mental illnesses as well, most notably bipolar disorder (Akiskal 2009).

It is important to acknowledge at the outset that language does not comprise the whole experience of mental illness. People experience both ordinary and unusual things that are not put into words, to others or even to themselves. Similarly, clinical observation does not directly take into account inner speech, or the words that people 'hear' in their heads, or 'say' to themselves. This is not accessible to others, except through the versions of inner speech that people attempt to share. Notwithstanding these limitations, clinical practice relies heavily on evidence gathered through spoken language.

Language is also critical to the delivery of treatment for mental illness. The first interventions when a person presents with mental health problems typically include psycho-education, which comprises an explanation of the problem in clinical terms, the evidence for the clinician's assessment of the issue, and the proposed treatment approaches. This initial therapeutic communication may be augmented by pharmacological, technological and behavioural interventions. These too are mediated through language, with explanations of the desired effects and potential side-effects of each intervention delivered prior to and throughout these therapeutic strategies.

In addition, language is also used to evaluate the effectiveness of treatment. In the first instance, this is assessed by the person's own statements about their response, literally, do they feel better or worse? This information can be corroborated by reports from other people in the person's life, with their consent. Clinical observations of language use conducted at initial assessment are also repeated, formally or informally, to note if there has been any change. Given the critical role played by language across all aspects of mental health practice, examining how language itself is currently understood is warranted.

CONTEMPORARY APPROACHES TO LANGUAGE

This study considered the influence of language on the experience of people with mental illness. The study used ideas from two contemporary approaches within the broader discipline of linguistics: cognitive linguistics and pragmatics.

COGNITIVE LINGUISTICS

'Cognitive linguistics is an approach to the analysis of language that focuses on language as an instrument for organizing, processing, and conveying information' (Geeraerts & Cuyckens 2007, p. 3). Commentators and critics alike agree that there is no standard unified approach that can be defined as cognitive linguistics, but there are a number of guiding principles. These have been summarised in a 'rough guide' to cognitive linguistics:

- Language is about meaning.
- Linguistic meaning is perspectival – Meaning is not just an objective reflection of the outside world, it is a way of shaping that world.
- Linguistic meaning is dynamic and flexible – meanings change.
- Linguistic meaning is encyclopaedic and non-autonomous – it is not separate from other forms of knowledge of the world that a person has.
- Linguistic meaning is based on usage and experience (Geeraerts 2008).

The first point is also the major challenge that cognitive linguistics addressed to the dominant approaches to the study of language throughout the twentieth century, the structuralist approach introduced by de Saussure (1916/1974), and Generative Grammar (Chomsky 1988), both of which give primacy to the rules that govern language use, rather than its role in interpersonal communication. Cognitive Linguistics asserts that meaning is created both in the traditional domain of word choice, covered in semantics, but also in the grammar of languages.

Geeraerts' (2008) second point can be seen as a weak version of a concept termed the Sapir-Whorf hypothesis, that, 'The language we speak influences the way we think.' (Kovecses 2006, p. 34). While the work on which this position was based has been criticised (Alford 1978), the deliberate manipulation of language to achieve desired ends persists in media, advertising and political discourse. Geeraerts' (2008) third point, that meanings change, can be demonstrated both historically, as the meanings of words change over time, and 'online' as inferences are created through the use of words in specific contexts.

The fourth point, that meaning is encyclopaedic, is also listed as a key principle by Croft (2009, p. 396):

> This principle implies that one cannot separate a subset of semantic features or predicates as constituting "the meaning" of a word or construction. Instead, all that the speaker knows about the real world experience denoted by the word or construction plays a role (however small) in its meaning.

This view can be contrasted with the idea that meaning can be contained within a dictionary, that is, fixed to a rigid, definable, unchanging set of criteria. This difference becomes important within the present study, in relation to how inferential meanings are constructed (Stein-Parbury 2014).

Geeraerts and Cuyckens (2007, pp. 3-4) summarise elements of the cognitive linguistic approach:

> Language, then, is seen as a repository of world knowledge, a structured collection of meaningful categories that help us deal with new experiences and store information about old ones. Specifically, language is a way of organizing knowledge that reflects the needs, interests, and experiences of individuals and cultures.

The implications of these ideas for a study of language use in mental health practice are clear. Language allows people to store knowledge about the world, but also enables them to deal with new experiences. Moreover, language reflects the needs and experiences of individuals and cultures. Mental health care frequently involves conflict; particularly when people experiencing psychosis or disorganisation encounter a mental health system that is designed to assist them, but also incorporates practices that seek to contain them and control their behaviour. This conflict is enacted through language, and the system's power stems in part from medical and legal discourses that may be completely new to the individual in need of help.

PRAGMATICS

Another approach to the study of language has run concurrent to the development of cognitive linguistics over the last few decades. Pragmatics is the study of language in use. Proponents have also distanced the approach from the formal approaches of de Saussure (1916/1974) and Chomsky (1988), but for different reasons than cognitive linguists. Where cognitive linguistics adopts insights from cognitive science, pragmatics is an extension of studies in the philosophy of language, specifically speech-act theory. The reasons for studying language as it is actually used by people are set out by Verschueren (2009, p. 2):

> Talking, or using language expressively and/or communicatively in general, consists in the continuous making of linguistic choices, consciously or unconsciously, for linguistic or extra-linguistic reasons… A theory of language use could and should therefore be conceived of as the study of the mechanisms and motivations behind any such choices and of the effects they have and/or are intended to have.

Again, the reasons why these ideas are important in a study of language use in mental health practice are clear, most obviously in the two binaries Verschueren posits as governing language choices. In the first instance, language choices may be conscious or unconscious. In the second, the reasons that motivate these choices may be internal to language, or related to dynamics external to language. Each of these aspects can potentially influence the inferences about meaning that are made in communication. A speaker may or may not be conscious of the impact their choice of a particular word will have on a listener. The inference a listener makes on hearing a term may relate to knowledge they have about the world of which the speaker is unaware. The applicability of these ideas in mental health practice relate to the range of influences on the inferences participants make in clinical communication.

In recent years, practitioners in both cognitive linguistics and pragmatics have noted that there were several areas of mutual interest in their approaches. Cognitive linguistics shared an interest in how linguistic meaning 'is based on usage and experience' (Geeraerts 2008, p. 5). Equally, pragmatics was alert to motivations and constraints on language use, which are cognitive processes. Cognitive pragmatics is a recent theoretical enterprise that reflects the similar objects of attention in language that characterise cognitive linguistics and pragmatics, notwithstanding the different theoretical provenance of the two disciplines. Schmid (2012, p. 3) offers a definition of the emerging field:

> Cognitive pragmatics focuses on the cognitive aspects of the construal of meaning-in-context. This pertains to both language production and comprehension, and it specifically concerns one of the key questions that pragmatics has set out to answer: What are the cognitive abilities and processes required to be able to arrive at “what can or must be said” in order to get across “what is meant” and to arrive at “what is meant” on the basis of “what is said”.

Cognitive pragmatics sets out a deliberate approach to answer pragmatic questions using cognitive means. Moreover it demonstrates significant parallels with mental health practice: mental health workers make decisions about what people mean, ‘on the basis of “what is said”’, and must use their ‘cognitive abilities and processes’ in order to effectively convey therapeutic messages.

METONYMY

Etymologically metonymy means ‘change of name’. Initially defined two thousand years ago as a figure of speech used in rhetoric (Al-Sharafi 2004), metonymy has come under renewed scrutiny in the last three decades within the discipline of cognitive linguistics, in which metonymy is viewed as strongly contributing to everyday language (Lakoff & Johnson 1980), and having powerful influence on inferences that are drawn in communication.

The title for my study is taken from the title of a book of essays, *Metonymy and Pragmatic Inferencing* edited by Panther and Thornburg (2003b). This volume was an early entry in the Cognitive pragmatic literature. In their introduction, the authors note that:

> Metonymies may be called *natural inference schemas,* i.e. easily activatable associations among concepts that can be used for inferential purposes (Panther & Thornburg 2003a, p. 8).

There tends to be more agreement about how metonymy functions pragmatically, than on how it is defined. Two problems confront a researcher attempting to provide a straightforward cognitive linguistic definition of metonymy in a study conducted outside the field of cognitive linguistics itself. The first is that, although cognitive linguists have many interesting things to say about metonymy, they don’t necessarily agree with each other, particularly when it comes to defining the concept. The second is that definitions frequently utilise terms that have specific meanings within cognitive linguistics that aren’t shared in the broader community, for example, ‘source’, ‘target’ and ‘domain’. These issues will be discussed in greater depth in Chapter 3: Metonymy. For now, I will adopt a suggestive attempt at definition of the term offered by Croft and Cruse (2004, p. 48).

> Metonymy is, loosely, the use of a word to denote a concept other than its 'literal' denotation. A cognitive linguistic analysis of metonymy is the ability of a speaker to select a different contextually salient concept profile in a domain or domain matrix than the one usually symbolised by the word.

In selecting a particular source (‘concept profile’ above) as salient in context, speakers draw the listener’s attention to the targeted meaning, and this practice is particularly effective in making communication economic. For example, in the sentence ‘Canberra announces policy changes’, the targeted meaning is ‘the Australian Federal Government based in Canberra’, but the source is simply the name of the city. That the speaker intends some form of governing body is inferred from the information that follows in the sentence itself, that is, the language-internal context. The particular source selected also effectively distinguishes which government is intended as the reference, through knowledge external to language, that is, which arm of government operates from this location. For most listeners, the correct pragmatic inference will be drawn from the use of the term ‘Canberra’ in this context, with less cognitive effort than processing ‘the Australian Federal Government based in Canberra’ would demand. Of necessity, the selection of one attribute of an entity or concept for attention relegates other aspects to the background (Langacker 1993; Talmy 2007). Conversely, attributes of the selected source can carry over into the target meaning, for instance, longstanding ideas about the city of Canberra that a listener holds. Both of these processes can lead to inferential effects that are not immediately obvious or predictable.

METONYMY AND MENTAL ILLNESS

Referring to a person by their diagnosis (e.g., ‘a schizophrenic’) is an example of metonymic linguistic practice; the diagnosis is selected as the salient attribute, and is used to stand for the whole person. It is a commonplace practice, and does not occur exclusively in the clinical settings where such salience is apposite, but can also operate in the home, the workplace and in social and other media. The metonymic use of mental health diagnoses as labels to stand for the people who experience mental illness contributes to stigma and depersonalisation. A recent survey conducted in Australia revealed the enduring prevalence of stigmatising attitudes toward people with mental illness, particularly those diagnosed with schizophrenia (Reavley & Jorm 2011). People who live with mental illness are not exempt from these stigmatising attitudes, and the problem of 'self-stigma' is associated with low self-esteem and poor outcomes (Corrigan, Kosyluk & Rusch 2013; Lysaker, Roe & Yanos 2006).

Beyond its role in underpinning the practice of stigmatising labelling, metonymy has a neglected history within psychiatry. Researchers in the 1930s and 1940s noted unusual speech patterns used by some people diagnosed with schizophrenia, which they linked to metonymy (Cameron 1944; Goldstein 1944). This was characterised as the use of idiosyncratically selected attributes to refer to things. It was regarded as inhibiting effective communication, and indicative of underlying thought disorder. The concept of 'metonymic speech' has received only intermittent attention in the following decades (Andreasen 1979a; Sadock 2009), and has not informed therapeutic approaches.

METONYMY AND THERAPEUTIC APPROACHES

It is in therapeutic approaches to managing stigma that the unnamed but implicit role of metonymy has been taken up. Stigma about mental illness remains prevalent, notwithstanding decades of work to reduce this. One way in which effective approaches work is by recreating a conceptual distance between the diagnosis or label, and the person to whom it is applied. This enacts a form of reverse-metonymy, countering the process by which a diagnosis is seen to 'stand for' the person. Given the ubiquity of metonymic referencing in everyday speech, addressing the power of stigmatising language is a complex undertaking, but it is a key aim for many people who live with mental illness and their advocates.

One approach that directly addresses stigma as part of therapeutic intervention is Narrative Therapy (White & Epston 1990). Drawing on sociological writings about stigma and marked identities (Goffman 1963), and philosophical work on the construction of modern identity (Foucault 1980), therapists working with this approach developed practices that extended beyond the focus on the individual in traditional psychotherapies. A key observation was that many people struggling with a range of mental health problems were hampered by modern notions of identity that link a person's whole identity to a specific attribute, often couched in vague terms such as 'burden' or 'worry'. When the selected attribute is somehow marked as negative, there is frequently a carry-over effect that the person has no capacity independent of the problem that they could potentially summon in dealing with the problem. Narrative Therapy maps sophisticated strategies for systematically addressing stigmatising language; the process whereby an attribute stands for a person's identity matches the cognitive linguistic definition of metonymy, and thus the strategies to remedy the process necessarily draw on recognition of metonymy's influence, though this has never been explicitly named in the key texts (Bird 2000; White 2007; White & Epston 1990).

THE EXPERIENCE OF METONYMIC LANGUAGE FOR PEOPLE WITH MENTAL ILLNESS

The metonymic transfer of meaning whereby a diagnosis of mental illness is selected as the salient attribute in their identity is an example of the power of inferencing. This holds whether the person adopts such an identity themselves, or if they find it imposed on them through stigma.

Less is known about the experience of language disorder in mental illness. Psychiatrists and psycholinguists have demonstrated the occurrence of language disorder, and conducted experimental studies of various patterns of idiosyncratic or disordered language use. However, there is little available evidence of what it is like to experience language disorder, as the majority of attention has been on the lived experience of positive psychotic symptoms, such as hallucinations and delusions. Consequently, it is not known whether therapeutic approaches that incorporate recognition of metonymic language used by individuals with mental illness, the clinicians who treat them and the broader community that interacts with them can influence these experiences.

This thesis is an examination of a number of these theories about language and mental illness, with one critical difference. Alongside an examination of the presence of many of the linguistic markers identified by previous researchers, the study also elicits the experience of using, and being subject to language, through the actual words of people who live with mental illness.

Study overview

This study consists of an exploration of the research questions, through nineteen interviews with ten participants who have a lived experience of mental illness that includes psychosis. Interviews were analysed thematically, to elicit participant's views on their experience. They were also analysed linguistically, to trace the presence of metonymy and other distinctive patterns in the language used by participants.

Chapter 1: the Introduction, sets out the aims and objectives of the research, and gives a brief overview and background to the key concepts in mental health practice and contemporary linguistics that underpin the study.

Chapter 2: Language and mental illness, examines in depth the relationship between the ideas being explored, and the various literatures these ideas arise from. This entails consideration of nursing, psychiatric, and counselling literature.

Chapter 3: Metonymy, addresses metonymy primarily from the perspective of cognitive linguistics.

Chapter 4: Method, details the specific methods used to collect and analyse data. The method combines elements from more than one research paradigm, and the reasons for methodological choices are described in detail.

Chapter 5: Results, reports on the analysis of the date provided by participants in the interviews.

Chapter 6: Discussion, examines how the results of the analysis of the data collected fits in with the questions asked in the Introduction and the previous literature discussed in the background chapters. This chapter also addresses the limitations of the present study and concludes with a consideration of the implications of the study for research and practice.

CHAPTER 2: LANGUAGE AND MENTAL ILLNESS

Introduction

This chapter considers the relationship of language and mental illness. In the first section, the role of language in contemporary psychiatric practice is summarised. This is followed by a review of historical approaches to the role of language in conceptualising mental illness. Other approaches to researching and treating mental illness, including mental health nursing and psycholinguistics, are then addressed.

Language is central to conceptualising and treating mental illness in contemporary mental health practice. This includes the processes of assessment and diagnosis, the delivery of treatment, and evaluation of the outcomes of treatment, from the point of the view of the person with the problem, and the person treating them. The importance of language is present across various disciplinary practices in mental health, including psychiatry, mental health nursing and counselling. The chapter critically engages with ideas from the different disciplines, in order to establish the rationale for the current study.

Diagnosis

Mental health diagnoses are made through language, with clinicians assessing the experiences that people describe, and the way that they communicate these experiences. These clinical observations are formulated into a diagnosis through matching them to categories defined in language in diagnostic manuals (American Psychiatric Association 2013). It remains the fact that physiological measures, typically used in medical diagnosis, are of minimal use in diagnosing mental illness as, ‘currently, there are no radiological, laboratory, or psychometric tests for the disorder(s)’ (American Psychiatric Association 2013, p. 101). Techniques provided through brain imaging technology can contribute to understanding of schizophrenia and other conditions, but they are only used negatively in clinical practice, that is to rule out the possibility that the presenting symptoms arise from an organic process.

SPEECH PRODUCTION: OBSERVATION AND INFERENCE

Serious mental illness is thus diagnosed principally through language, in particular through observations of the presenting person’s speech production. The predominant research on language and mental illness has been conducted on schizophrenia. This is reflected in the prominence of speech disorder in the diagnostic criteria for the condition. The latest version of the *Diagnostic and Statistical Manual of Mental Disorders DSM 5* includes ‘disorganized speech’ as one of three characteristic symptoms, along with delusions and hallucinations, that must be present for a diagnosis of schizophrenia to be made (American Psychiatric Association 2013). The *DSM 5* specifies that:

> *Disorganized thinking (formal thought disorder)* is typically inferred from the individual’s speech… Because mildly disorganized speech is common and nonspecific, the symptom must be severe enough to substantially impair effective communication (American Psychiatric Association 2013, p. 88, italics in original).

There is considerable room for variation in the application of this diagnostic criterion. The measure used to determine that observed disorganised speech constitutes a symptom is the psychiatrist’s assessment that it has led to substantially impaired communication. This carries the presumption that any communication failure rests with the individual under assessment, and not with the practitioner. This presumption is inconsistent with how communication operates dynamically, by definition, between two or more people (Jakobson, Pomorska & Rudy 1987). The pragmatic understanding that inferences may be conscious or unconscious, and related to external influences (Verschueren 2009) is also absent, notwithstanding the reliance on inference to make the diagnosis.

Disordered speech production has been further differentiated into aspects demonstrating positive and negative thought disorder:

> Positive thought disorder includes tangentiality, derailment, neologisms and several other phenomena that appeared to be highly correlated in patients...Positive thought disorder is now generally conceptualized as part of the disorganization sub syndrome of schizophrenia. It is also termed disorganized speech (Kuperberg & Caplan 2003, p. 447).

The delineation of the disorganisation sub syndrome is in line with the dimensional approach to assessing mental illness, which focuses on the particular symptoms experienced by people, rather than which diagnostic category these symptoms place them in. This approach is intended to address some of the limits of the categorical approach, such as difficulties drawing the boundaries between certain diagnoses (American Psychiatric Association 2013). The dimensional approach extends the earlier division between positive and negative symptoms by adding the disorganisation, or cognitive impairment sub syndrome, and also recognising the presence of mood symptoms in formulating treatment plans. In this model, negative thought disorder which includes poverty of speech, and poverty of content of speech, is considered as part of the negative sub syndrome of the illness (Kuperberg & Caplan 2003).

Formal aspects of produced speech as markers of thought processes are also used in the diagnosis of bipolar disorder:

> Thinking processes are accelerated, subjectively experienced as flight of ideas, and thinking and perception are unusually sharp. The patient may speak with such pressure that associations are difficult to follow; such "clang" associations are often based on rhyming or chance perceptions and can be lightning fast. The pressure to speak may continue despite the development of hoarseness (Akiskal 2009, p. 1704).

In order to describe the presentation of thought in bipolar disorder, the author uses figurative language, ‘flight of ideas’ and ‘lightning fast’, and inexact measures to determine pathology, ‘unusually sharp’. The clinician can determine that a perception is ‘chance’ without knowledge of the other person’s inferential schema.

It is clear from these examples that a critical element of the diagnostic process is reliance on the inferencing practised by clinicians. Moreover, these clinical approaches typically sidestep the longstanding controversy around the relation of speech to thought, opting for a general acceptance that thought is relatively transparently conveyed through speech. Andreasen and Grove (1986, p. 348) make explicit the short-cut taken in clinical practice:

> While it is also possible to obtain indices of cognitive performance or 'thought' using formal tests to elicit disordered thinking, such as proverb interpretation or projective tests, in a clinical setting we usually infer a person's thoughts directly from his speech.

A contemporary description of this inferential process introduces an analogy equating psychiatric observation of language with technological approaches used elsewhere in health care:

> As a primary care physician uses the fundoscopic examination as a way to visualize the vasculature of the central nervous system (CNS), in psychiatry speech is examined as a means to determine a patient's verbal cognition (Lewis, Escalona & Keith 2009, p. 1448).

The observation of language to infer the presence of thought disorder and diagnose a person with mental illness is a significant clinical responsibility. The diagnostic criteria outlined above are drawn from a diagnostic manual and a key textbook, both used as references by practitioners, and as tools to prepare future mental health workers. The language they use is figurative, inexact and inconsistent with current theories of how language operates.

Compare Hobbes (1650/2011, p. 49), writing over 300 years ago, describing his own thought patterns, which include a seemingly chance perception arrived at through quick but coherent thought:

> In a discourse of our present civil war, what could seem more impertinent than to ask (as one did) what was the value of a Roman penny? Yet the coherence to me was manifest enough. For the thought of the war introduced the thought of the delivering up the King to his enemies; the thought of that brought in the thought of the delivering up of Christ; and that again the thought of the thirty pence, which was the price of that treason: and thence easily followed that malicious question; and all this in a moment of time; for thought is quick.

There is, if anything, less figurative language in Hobbes' (1650/2011) account than in the diagnostic criteria previously described. He also highlights how negative inferences made about instances of speech ('impertinent', 'malicious') can miss their underlying coherence.

Variation in application of diagnostic criteria has been observed occurring:

> Certainly, different societies, different individuals and even different clinicians have a variety of thresholds for both noticing atypicality and for labelling it pathological (Fine 2006, p. 300).

The inexact and under specific language in the current written tools used to support and develop clinicians to effectively diagnose mental illness does not adequately protect against such variation. This has implications for the people who are diagnosed with mental illnesses.

SPEECH PRODUCTION: CONTENT AND FORM

In the clinical observation of speech production, a division is made between the content of what people say, and the form in which they say it. The content of speech is a key element of the clinical assessment process. The person may describe thoughts or emotions that are different to their previous thoughts and emotions, and are unwelcome. They may describe beliefs about things that are not shared with anyone else, are not consistent with external evidence, and evince dramatic shifts from their previously held beliefs (delusions). They may describe the experience of hearing or otherwise sensing things that no one else can hear (hallucinations). They may explicitly describe what they hear. They may describe their mood, and their experience of alterations in mood. They may describe changes in thinking that are congruent with these moods or not. The terms they use for these experiences may be drawn from a range of available discourses, including but not limited to psychiatry. Thus a person may report that they experience auditory hallucination, or they hear voices, or they hear someone talking to them. Each of these terms, while possibly describing the same phenomenon, carries different inferences.

Behavioural manifestations of altered reality must also be described in language to form part of the clinician's formulation of the problem. In the situations described above, it is the content of the person's speech that contributes to the formulation of the problem, and to this extent, the pattern of communication between person and therapist is reasonably straightforward. In assessments, clinicians need to be sensitive to cultural differences in beliefs, for example, in numerous cultures it is not considered abnormal to believe that the voices of one's ancestors speak directly to people. In other cultures it is typical for mood to be communicated in somatic terms. Content of speech can often be corroborated by information from others, though this is not always undertaken.[1]

The form of speech refers to the manner in which the person speaks, distinct from the content of what they say. Observations of speech form can include the rate of speech, the typicality of constructions, the recurrence of terms, and the congruence to the current topic. These alterations in the formal aspects of speech range from mild to severe. Mild alterations can seem little different to the idiosyncratic speech patterns of all speakers, for instance, the habit of circling around a topic (circumstantiality), or answering questions in tangential or elliptic ways.

In order to more clearly define the formal deviations in speech that could be used in formulating differential diagnoses of mental illness, Andreasen (1979a, 1979b) developed the Thought, Language and Communication Scale. This work built on earlier

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[1] A colleague with a name that is unusual in the Australian context once discovered a person she cared for had been hospitalised in a different area. She phoned to enquire about the person's welfare, and when she identified herself, the clinician paused then stated, 'Oh, you're real'. From lack of cultural familiarity with the worker's name, the treating team had inferred she was a delusional construct of the person they had detained.

descriptions of commonly observed patterns of language, including terms used by Kraepelin (1919/1999) and Bleuler (1911/1950). Eighteen different patterns of formal speech disorder are described, with each given specific criteria, examples, and important exclusions. Metonymy is included in the category of 'word approximations' (Andreasen 1979a). Further work used sub-sets of observed patterns of speech to differentiate between sub-syndromes in schizophrenia, and determine prognostic features (Andreasen & Grove 1986).

While Andreasen's (1979a, 1979b) work has continued to be used in research contexts (see e.g., Docherty 2012), it is not included in teaching and reference materials, except in diluted forms. Current textbooks typically include long lists of signs of formal speech disorder, but these are defined very briefly, with minimal comment about the relative frequency of these patterns, or indications about what they may suggest in terms of differential diagnosis. For instance tangentiality and derailment are both defined as moving away from the topic, but the key differential element, that tangentiality is in response to a question, while derailment occurs within a person's own speech, is not included (Sadock 2009).

SPEECH COMPREHENSION

Speech comprehension has traditionally been given less attention than speech production in the diagnostic process (Kuperberg 2010a). Some people with schizophrenia experience particular difficulty comprehending the speech of others. This can relate to specific aspects of speech, like interpretation of figurative language, or idioms. Or it can relate to following the course of a conversation when the meaning they understand a word to have does not fit with the context, and they cannot correctly interpret the intended inference.

Asking people to explain common proverbs, for example, 'A stitch in time saves nine', previously formed a standard part of diagnostic procedures, used to determine if people could think in abstract ways, or were constrained to the concrete meanings of terms. This practice has reduced in recent times, as clinicians became more aware of the cultural biases that inform many proverbs, leading to incorrect conclusions being drawn based on proverb tests. Nonetheless, for certain subgroups of people with schizophrenia with shared cultural backgrounds, researchers have observed differential patterns in interpretation of speech, particularly in interpretations of figurative language and indirect requests (Champagne-Lavau & Stip 2010; Chapman 1960).

For people experiencing paranoia, speech comprehension can be characterised by heightened vigilance, with seemingly unloaded terms being recognised by the individual as specifically referential within their schema. This is not restricted to linguistic messages. People have reported ‘reading’ specific messages intended for them in the paralinguistic form of vehicle number plates and even in the colours of passing cars.

DIAGNOSTIC HETEROGENEITY

A further complication in formulating mental health diagnoses is that each diagnosis can be applied to a heterogeneous group of symptoms. Using the *DSM 5* criteria (American Psychiatric Association 2013), one person may be diagnosed with schizophrenia who has experienced delusions, but never experienced a hallucination, while another may have had mild voices and a history of disorganised behaviour, but never had a delusion. This disparity is not clear to the people who receive the diagnosis, and may lead to confusion, particularly if they don’t have symptoms that form part of the cultural image of the illness to which they had been previously exposed. For instance, people who have never experienced hallucinations may query why they have been diagnosed with schizophrenia, and others who have never experienced depression question how their mood can be called ‘bipolar’.

Equally, symptoms can occur across a number of diagnoses. A person who has experienced hearing voices may find themselves diagnosed with schizophrenia, schizoaffective disorder or bipolar disorder, depending on the co-presence and timing of other symptoms related to changes in their mood. This variation can easily lead to confusion in people and their family members grappling with their entry into the mental health care system.

FIGURATIVE LANGUAGE

Figurative language is prevalent in the clinical descriptions of language disorder in the diagnosis of mental health. Examples from the diagnostic literature include, ‘flight of ideas’ and ‘lightning fast’ (Akiskal 2009, p. 1704), ‘derailment’ and ‘tangentiality’ (Sadock 2009). The use of figurative terms to describe phenomena observed in mental illness dates back to the early days of psychiatry. Eugen Bleuler coined the term ‘schizophrenia’ in 1908. Fusar-Poli and Politi (2008, p. 1407) describe the process:

> Bleuler collected material directly from his passionate clinical work. By accommodating himself to the spatial and temporal environment of his patients, he realized that the condition was not a single disease…was not invariably

> incurable, and did not always progress to full dementia… the splitting of different psychological functions, resulting in a loss of unity of personality, was the most important sign of disease in Bleuler's conception. Thus, he challenged the accepted wisdom of the time and advanced his purportedly less static and stigmatizing concept by juxtaposing the Greek roots *schizen* (to split) and *phren* (originally denoting "diaphragm" but later changing, by metonymy, to "soul, spirit, mind") (italics and parentheses in original).

It is ironic that the term schizophrenia was deliberately constructed to counter a stigmatising conception inherent in the previous term *dementia praecox*, but that name has subsequently accrued a heavy burden of stigma in popular consciousness. Bleuler's (1911/1950) deliberate use of figurative terms in developing a new conception of the illness was linguistically transparent.

The use of figurative language in psychiatry is still prevalent. As discussed above, published definitions tend to be underspecific. From a cognitive linguistic perspective, the source of each term would not be sufficient to allow clear access to the target meaning, and could be intrusive to the point of misleading. For instance, 'derailment' brings to mind a train coming off the rails and stopping, catastrophically or otherwise, but the language pattern the term describes in psychiatry in fact does not necessarily entail that speech comes to a halt. This can affect the communicability of clinically observed signs, particularly between mental health workers and the people actually experiencing these symptoms of mental illness.

The use of figurative language in clinical communication has been specifically addressed by a few authors (Crawford et al. 1999; Hamilton & Manias 2006). Though these articles focus more on how mental health workers communicate to each other about people with mental illness, they do trace the potential influence of this on clinician's direct communications with the people they treat. One recent Australian textbook advises against any use of figurative language altogether, due to the potential for inferences to be confusing across cultural lines (Candlin 2008), however this recommendation is not accompanied by pragmatic suggestions for communicating without figurative language.

Delivery of treatment

Therapy for mental illness is multidimensional: treatment comprises psychological, pharmacological, technological and behavioural interventions. Many mental health professionals use more than one treatment approach in their work, either as sole practitioners, or collaboratively with members of other health disciplines. Thus a person may see a medical professional who prescribes medication and monitors its effects, and a nurse or other qualified mental health professional, who engages in counselling. Alternately, a psychiatrist could function as both prescriber and counsellor. Even in the rare cases where treatment is exclusively pharmacological, formulation of the diagnosis, explanation of the proposed treatment, and monitoring of its effectiveness all proceed via language, and are therefore mediated by language.

An important element in the delivery of treatment is interpersonal communication. Mental health workers communicate their ideas to the people who consult them about mental health problems. Moreover, workers communicate to each other. In doing so, the choice of language used can set up inferences that extend beyond the explicit. There are gaps between the types of language used by different disciplines.

There is extensive literature on effective therapeutic communication (see, e.g. Peplau 1952/1988; Stein-Parbury 2014) however, notwithstanding the comprehensive attention thought disorder and communication difficulties have received, this has not translated into interventions directly targeting problems with speech comprehension or production. Bowie and Harvey demonstrated a positive correlation between communication difficulties and poor social outcomes for a population with schizophrenia (Bowie & Harvey 2008). This finding was confirmed by Tan and colleagues, in a younger population living in the community (Tan, Thomas & Rossell 2014). These authors recommend that rehabilitation include focus on improving communication, but there is limited literature on implementation of this approach (Holshausen 2012). Studies have reported the effects of social skills training (Mueser et al. 2010) and cognitive remediation (McGurk et al. 2007), but to date neither of these approaches have explicitly targeted language skills development.

Only one study was located that specifically addressed language difficulties in schizophrenia from a speech therapy approach (Clegg et al. 2007). Unfortunately, the intervention, though deemed to have some benefit, involved a team engaging in weekly speech therapy sessions with one person throughout the course of a nine-month inpatient admission, and is thus not practicable in clinical services. Interventions targeting the processing of figurative language have been reported in a population of people with autism who experience related communication difficulties (see, e.g. Melogno & Pinto 2014), however the literature does not yet include evaluation of the effects.

Evaluation of treatment

Evaluation of the outcomes of mental health practice is also conducted through language. In the first instance, the person may report feeling better. This can be a report of the absence or quieting of hallucinations, or shifts in disturbing beliefs, or a sense of stability in mood. These changes can be accompanied by evidence from other aspects of the person’s life, for example, better relationships with other people in their life, and/or return to work or study. The person’s report can equally be corroborated by reports from others in a position to provide useful information, such as family members.

In cases where the problem has manifested in disorder of speech, observed changes in speech production can be used to evaluate treatment. If a person whose speech production was generally incomprehensible to the intended audience develops the capacity to communicate more clearly, this is interpreted as a sign of clinical recovery. In extreme cases this is relatively easy to assess.

Such an assessment of recovery leaves an unresolved question. There are no routine measures of normal speech production, and idiosyncratic patterns of speech can be argued to be completely unrelated to mental health problems. Nor are the measures by which a person’s speech is deemed unintelligible or opaque clearly agreed upon. Evaluation of clinical recovery therefore includes variation, and subsequently a significant margin of error.

Observations can be formalised in outcome measures, which are tools used to evaluate the effectiveness of interventions at a population level as well as for the individual (see, e.g. Rosen, Hadzi-Pavlovic & Parker 1989; Wing et al. 1998). These measures have an increasing importance in the kind of services that are made available to people. Items are rated on scales, and reported as quantitative data, but the initial items are described, and subsequently rated, in language. Lewis, Escalona and Keith (2009) have identified the risk attendant on the use of such scales:

> But the existence and reliable utility of these scales has nonetheless had the unintended effect of focusing researchers' and clinicians' attention on the questions asked by the scales and diverting some attention away from the stories patients have to tell. The scales, like the brief and reliable contemporary diagnostic criteria we apply, have become the illness in the mind of many in mental health, and so the individual experience of patients suffering with the illness does not always have a place in clinical interviews.

This observation suggests a metonymic influence on researchers and clinicians attention, whereby the measures used to report outcomes come to stand for the experiences of the people they treat.

Medico-legal implications

If a person is determined by psychiatrists to have a mental illness that requires treatment in order to prevent harm occurring to the person themselves, or to others, they can apply for a legal order that directs the person to accept the prescribed treatment whether they consent or not. These directions can set out the physical location in which a person is treated, to the extent that a person may find they are involuntarily confined in a hospital for a set period of time. This is experienced by many as a deprivation of liberty akin to being imprisoned as punishment for a crime. People can also be required to accept treatment with medications that change the way they feel, and result in side-effects, such as sedation and weight gain, that alter their experience, and potentially their sense of identity.

These processes occur through language, and introduce a further discourse, legal language, to the already unfamiliar medical discourse framing the materiality of the person’s experience. In Australia, mental health legislation is established and enacted at a jurisdictional level, that is, by each of the states and territories. In the absence of consistent national mental health legislation, people can discover that they have different rights in different jurisdictions. Jurisdictions periodically review their mental health legislation, and this typically involves changes in the language used, in particular to reflect evolving principles about the capacity of people with mental illness to engage in decision making about their treatment (see, e.g. Mental Health Act (Victoria) 2014; Mental Health Act (Western Australia) 2014).

The possibility that a person may become subject to a legislative order that allows for treatment to be provided coercively introduces a further consequence to clinical assessment of speech:

> There can be tendencies, and more or less legitimate reasons, to keep silent, *not* to convey what one saw, did or experienced (Fischer-Rosenthal 2000, p. 119).

Fischer-Rosenthal (2000) is an historian whose work included interviewing German people about their actions during World War II. However, his statement that people may have what they regard as legitimate reasons not to disclose their experience resonates with the situation of a person undergoing a mental health assessment with the prospect that they may be detained against their will in a mental health unit. In a clinical observation, Andreasen (1979a, p. 1316) noted that:

> Anyone can exert conscious control over his language behaviour and manipulate it in various ways to conceal or obscure his thoughts.

Other authors have noted that a person's use of language may not be deliberately deceptive, but nonetheless obscure. Where Andreasen (1979a) highlighted conscious determination to avoid transparent communication, Peplau (1952/1988, p. 197) identified psychological reasons that can interfere with people expressing themselves clearly:

> The patient cannot be forthright about expressing the meaning of events and so often uses a highly disguised way of saying what is felt. Nurses can speculate on the meaning and often come close to what it actually means to the patient.

This is a clear statement that effective listening involves nurses (and, by extension, other mental health workers) practising skilled inferencing. Menzies Lyth (1989, p. 28) asserts a more radical psychoanalytic position:

> It is obvious that people do not say what they really mean even when they honestly and sincerely say what they consciously think, let alone when they do not.

This invokes the famous title of an influential essay by the language philosopher Cavell (1958), '*Must we mean what we say?'* which examines the gap between semantic and pragmatic meaning and the consequent inferences and implications that arise in language use. Cavell (1958, p. 181) states that:

> *Learning what these implications are is part of learning the language;* no less a part than learning its syntax, or learning what it is to which terms apply: they are an essential part of what we communicate when we talk (italics in original).

The complexities of communication in general that have been identified by these authors do not figure in the way that language is portrayed in psychiatric textbooks (e.g., Sadock 2009) and diagnostic manuals (American Psychiatric Association 2013). Similarly, the suite of mandatory assessment documentation to be completed by public mental health workers in NSW does contain an item for 'Communication Issues' but the suggested prompts are limited to 'language or cultural barriers, sensory impairment'

(Mental Health and Drug and Alcohol Office 2008). Clinicians are therefore not supported to consider the influence of linguistic features in the inferences they draw and respond to, either in their training or in their practice. This has implications for their medico-legal decision making, which in turn has implications for people who live with mental illness.

Historical approaches to language and mental illness

This section presents a selection of earlier approaches to language and mental illness.

EARLY TWENTIETH CENTURY APPROACHES

Psychiatrists from the beginning of the twentieth century have studied how language provides information about mental illness. Bleuler (1911/1950, p. 150) gave numerous examples of the language of his patients, including this metonymic substitution:

> Sometimes the figures of speech misuse the principle of *pars pro toto*, in such a way that its least essential component is selected to represent the total concept. For example, a shoe is called "something used to dance in".

Bleuler (1911/1950) uses a Latin phrase, '*pars pro toto'* which translates as part for whole, that is, one of the classic forms of metonymy. While noting the phenomenon, he did not refer directly to 'metonymic speech'. Blueler (1911/1950, p. 150) further notes that:

> Frequently, the similarity of concepts which leads to the interchange of words is an extremely tenuous one and involves thought processes which have no connection with the thought being expressed… Sometimes the similarity is not in the concepts but rather in the words, this can result in dull plays on words.

Many of Bleuler's (1911/1950) ideas have been taken up by later researchers, including the phenomenon he described above, where word use can be prompted not by context, but by associations with the sound or meaning of the actual words, which would later be developed into the concept of semantic priming. The language evidence Bleuler (1911/1950) reported arose from the speech of patients in his care. He focused on their speech production, rather than their comprehension. The context for their speech is not explicitly described, but can be understood to occur in clinical discussions between patient and psychiatrist. Bleuler was alert to the fact that speech does not exactly mirror thought and that shifts can occur at the level of words only, but also between concepts and words.

Where Bleuler (1911/1950) observed deviations in figurative speech production in his patients, Vygotsky (1934/1994, p. 321) observed difficulties they had in comprehension:

> Most remarkable was that I found disturbances in the understanding of words figuratively used, even when there was no apparent disturbance of intellectual life in general. This difficulty became very obvious when special words or concepts were used. While the normal mind has no difficulty in using given words metaphorically or figuratively, the same problem presents insurmountable difficulty for the patient with schizophrenia in spite of the fact that he has retained from childhood the habit of using figures of speech, proverbs, etc.

Much of Vygotsky's (1934/1994; 1934/1986) work concentrated on the acquisition and development of language in children, and he spent time exploring the theory that schizophrenia represented a regression to a less sophisticated way of thinking, made manifest as an incapacity to process figurative language. Cameron (1938) studied this theory experimentally, and concluded that regression was not an accurate model for the characteristic speech observed in people with schizophrenia. The theory of schizophrenia as regression was abandoned at this time.

1930S AND 1940S: METONYMIC DISTORTION

During the 1930s several psychiatric researchers were pursuing studies on the relationship between language and mental illness. The pattern of speech production previously observed by Bleuler (1911/1950) was defined as metonymic by Cameron (1938, p. 20), drawing on traditional rhetoric:

> *Metonymic distortion* consists of the substitution of an approximated but related term or phrase for the more precise definitive term that normal adults would presumably use in the same setting (italics in original).

In a later study, he writes of the effect of this type of speech on the listener, and expands on how difficult it can be to interpret:

> The result is analogous to what one gets in looking at something through steamed glasses. One patient says that he "has menu three times a day" instead of food or meals. Taken in the frame of the individual patient's life and his known fantasies, these sentences can be translated into more precise, socially current forms. It is this need for continual translation and sharpening of

> the focus that confuses and fatigues the listener. It gives the same feeling of strain that comes when one tries to follow a conversation in a foreign tongue with which one has some acquaintance but not quite enough. One goes along for a bit all right, but then begins to slip behind and miss the meaning (Cameron 1944, p. 54).

Cameron (1944) identifies that the terms chosen, while seemingly idiosyncratic and superficially opaque, can frequently be correctly inferred when the broader context of the speaker's language practice is understood. This is another example where the writer resorts to figurative language, here analogy, to convey an aspect of clinically observed language, in this instance comparing comprehending the speech of a person with schizophrenia to understanding someone speaking in a foreign language and to looking through steamed glasses.

Cameron (1944, p. 54) is not immune to a particular irritation that characterises responses (see, e.g. Bleuler 1911/1950; Chapman 1960) to the language of people with mental illness:

> It is often striking how well satisfied many of them are with their very inadequate communication, showing little or no evidence of concern over its unintelligibility. They either fail to recognize that you are having trouble or they are haughty about your stupidity.

This comment does provide insight into the communication style some people with schizophrenia used prior to the advent of anti-psychotic medication.

Cameron (1944) reported his work to the American Psychiatric Association in 1939. Another researcher at the same conference reported on the speech production of people with schizophrenia in a quasi-experimental study:

> "...in the color-sorting test one of our patients picked out various shades of green, but in doing so he named them as peacock green, emerald green, taupe green, bright green, equet green, bell green, baby green. He refused to say that all might be called green. Another patient said, in the same situation, "This is the color of the grass in Virginia, this is the color of the grass in Kentucky, this is the color of the bark of the tree, this is the color of the leaves" (Goldstein 1944, p. 26).

Goldstein (1944) presents this as indicative of a type of failure in the communicative task, that is, the 'correct' answer was in fact 'green', and the participants were unable, or perhaps unwilling, to produce this answer. Yet both respondents do provide answers that suggest acute powers of observation even as they exceed the task at hand. The second person's reported choices bear this out even more spectacularly, evincing an awareness and attendance to perceptual shifts that elude most of us. The second response, provided under quasi-experimental conditions, actually falls into repetitive and sophisticated rhythm, the dactylic, or 'heroic' hexameter used by Homer (Thalmann 1984), thus demonstrating extraordinary skill at manipulating aspects of language not restricted to simple conveyance of meaning.

Goldstein (1944, p. 25) is not insensitive to the motivation for this language choice, despite it not meeting the ostensible goal of the test:

> Analysis reveals that many of the very strange words which the patients use become understandable when considered in relation to the concrete situation which the patient experiences at the moment and which he wants to express in words. In their language there is an absence of generic words which signify categories or classes.

The link between these examples and metonymy is that what can be interpreted as unrelated to the topic by a clinician or a researcher may be the result of the metonymic selection of an attribute by the speaker that is not immediately clear to the listener within the context. Here the determination of the context is set by the clinician or researcher, hence the frustration in relation to the colour-sorting tests. For the researcher, there is one 'right' answer, which is an accepted generalisation, conforming to a specific level of categorisation. On the other hand, for the respondents the naming task is correctly completed using terms sourced from their lived experience of colour, illustrating Rosch's (1978) observation that people frequently select category levels based on embodied experience.

METONYMIC SPEECH IN SUBSEQUENT PSYCHIATRIC DISCOURSE

Metonymic distortion, subsequently referred to as metonymic speech, has attracted variable interest as a concept in psychiatric research and clinical practice. Post-war psychiatry was heavily influenced by the rise of behaviourism, and the introduction of the first anti-psychotic medications. The term was included as a sub-type of the category 'word approximations' in Andreasen's Thought Language and Communication Scale (1979a). It has resurfaced in a 2009 textbook, with one of the examples, of 'a menu' standing for 'a meal' being taken (without credit) from Cameron (1944):

> Metonymy: Speech disturbance common in schizophrenia in which the affected person uses a word or phrase that is related to the proper one but is not the one ordinarily used; for example, the patient speaks of consuming a menu rather than a meal or refers to losing the piece of string of the conversation rather than the thread of the conversation. See also paraphasia and word approximation (Sadock 2009, p. 925).

Another aspect of this reappearance is that metonymy is described as a 'common' speech disturbance in schizophrenia, despite minimal evidence to this effect (Andreasen 1979b; Andreasen & Grove 1986).

The observations about metonymy and its influence on communication made by these early researchers (Cameron 1944; Goldstein 1944) generate striking resemblances with the way the concept is later mapped by cognitive linguists, but to date no reference to this work in contemporary cognitive linguistics literature has been located.

STUDIES FROM THE SECOND HALF OF THE TWENTIETH CENTURY

While relatively neglected in psychiatric research in the second part of the twentieth century, the language used by people with mental illness became a subject of interest for researchers in other disciplines during this period. Chapman (1960), a linguist, undertook an influential study of comprehension of literal and figurative language by people with schizophrenia, people with brain damage, and a control group with no known morbidity.[2] Chapman looked at differences in how people with schizophrenia figuratively misinterpret set examples of literal language, and literally misinterpret set examples of figurative language, and identified a trend toward the latter, suggestive of a certain fixity of the meaning of words held by people with schizophrenia that is relatively insensitive to changes in context. Chapman (1960, p. 413) also expressed frustration as a researcher:

> Errors are made for many reasons besides the kind of misinterpretation under investigation, and the bases of these errors are mostly unidentified. For example, many schizophrenics are non-cooperative and respond carelessly, mark randomly, mark by position, or mark in response to other characteristics of the test which are difficult for the examiner to identify.

In fact, many of the researchers who decry the difficulty (or tedium) of communicating with people with schizophrenia are in fact complaining of frustration at not receiving

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[2] The 'control' cohort for the study were noted to comprise 23 medical students from the researcher's own faculty, and 13 firemen stationed nearby.

answers that suit their particular research or diagnostic question (Bleuler 1911/1950; Chapman 1960; Goldstein 1944).

Goffman (1963, p. 129), a sociologist, highlighted the negative effects of communication problems not just on the people who experience them, but also on the broader community:

> Failure to sustain the many minor norms important in the etiquette of face-to-face communication can have a very pervasive effect upon the defaulter's acceptability in social situations…A solution was for the individual who cannot maintain an identity norm to alienate himself from the community which upholds the norm, or refrain from developing an attachment to the community in the first place. This is of course a costly solution both for society and for the individual, even if it is one that occurs in small amounts all the time.

Goffman (1963) introduced consideration of what the experience of communication problems is like for the individual. He also explicitly addressed the issue of the cost that accrues to society as a whole as a result of this alienation of its members.

Rochester and Martin (1979) published *Crazy talk: a study of the discourse of schizophrenic speakers,* a study focussed on speech production by people with schizophrenia. They were critical of previous studies that automatically conflated thought with speech. They were also critical of experimental linguistic studies, preferring speech in context:

> Investigators of schizophrenic speech have attempted to characterize those features of the corpus that differ from normal. In effect, the effort has been to describe the failures rather than the overall performance of the schizophrenic speaker (Rochester & Martin 1979, p. 24).

They conducted a series of studies that attempted to bridge the divide between experimental and context-based research, requesting participants in their cohort to verbally describe pictorial cartoons they were shown, and also to re-tell brief narratives. Their observations included that:

> Taken most generally, the clinical and experimental evidence suggests that schizophrenic patients attend more strongly to lexical items than to the contexts in which those items are used. This means, roughly, that schizophrenic speakers are more likely to focus on lexical meaning in their discourse than on the meaning of whole clauses or the way in which clauses are related. And it

> indicates that schizophrenic listeners are more likely to be biased by the "strong" or "preferred" meaning of a word than the meaning of a word in its sentence or discourse context (Rochester & Martin 1979, p. 91).

This phenomenon can be linked to the position taken by cognitive linguists that speakers generally hold an ‘encyclopaedic’ notion of the meaning of a particular word rather than a ‘dictionary’ one (Croft & Cruse 2004).

Researchers who have investigated language for its capacity to assist with differential diagnosis have conducted semi-structured interview schedules designed to avoid discussion of pathology, in the interests of rendering the rater ‘blind’ to the diagnosis. Interestingly, there was less attention to the influences of the so-called ‘neutral’ topics chosen may have on the language choices, and hesitations of participants. For instance, Andreasen & Grove (1986, p. 349) included discussion of ‘politics, religious beliefs, and family life’. While such topics do not provide information about psychiatric diagnoses, they stray into areas which have typically been considered to invoke social awkwardness, which would then be a factor that would alter the data collected. Another group used the Indiana Psychiatric Illness Interview, about which they say: ‘This measure differs from other psychiatric interviews in that it does not introduce content’ (Lysaker et al. 2005, p. 67). However, by asking participants how their condition ‘controls’ their life and how they ‘control’ their condition, the researchers introduce very specific content, inducing inferences of power that are leading in terms of language choice.

At the turn of the new century, McKenna and Oh (2005) published a critical history of language studies in schizophrenia, with particular focus on the ways in which researchers have attempted to resolve the issue of the relation of speech to thought disorder. They take up the concept of a breakdown in linguistic competence occurring in schizophrenia:

> Unlike patients with autism and Asperger's syndrome, who fail to develop the ability to make inferences about the mental states of others, in schizophrenia there would likely be a breakdown in an ability the patients once had. This would cause them to continue to try and make inferences but to find the process difficult and produce ones that were faulty (McKenna & Oh 2005, p. 118).

This echoes the abandoned concept of schizophrenia involving regression (Vygotsky 1934/1994), in that it describes a ‘breakdown in an ability the patients once had’.

However, while the authors reported that people with schizophrenia may continue to make failed attempts to correctly draw inferences, they do not suggest that they revert to the kinds of inferences they made as children.

Approaches to language and mental health beyond psychiatry

This section will consider how other disciplines approach the issue of language and mental illness, and will consider those works that throw light on the current approach.

NURSING

Significant work that has been published within nursing literature that takes into account the subtleties of communication and inference. Peplau, writing in the 1950s, was strongly influenced by the psychodynamic work of the psychiatrist Harry Stack Sullivan. She addressed her work to interpersonal relationships between nurses and patients in all settings, including the role of communication within these relationships:

> Nurses use words in many ways in their relations with patients. They communicate facts, they converse about everyday events, they convey interpretations of events that occur in carrying out the plan of treatment. Concepts, words, or symbols chosen to express ideas, thoughts or feelings, or to indicate objects referred to, often determine whether the tool -- language -- will be helpful in the reshaping of experience or whether it will operate as a detriment to elaboration of meanings of events (Peplau 1952/1988, p. 289).

The key element for the present study that was identified by Peplau is that the choices nurses make in their communications with people can influence the outcome in terms of the person’s experience. Peplau (1952/1988, p. 307) clearly states the approach to language that nurses should adopt in approaching this work:

> In relations with patients nurses can attend precisely to the way in which a difficulty is stated by the patient. The exact wording is more important than abbreviated or cryptic recordings of the complaint.

Sixty years later, Stein-Parbury (2014, p. 195) makes explicit the power that nurses can exercise when they choose to pick up on inferences from the people they are caring for, or ignore them:

> Cues are small units of information that are part of a larger, more complex phenomenon. They indicate a need for further exploration into the

> phenomenon...Sadly, nurses frequently either fail to acknowledge patient cues or even actively discourage further exploration of them.

While these authors are not specifically addressing mental health nursing, their observations apply to the field as well as to nurses in general settings.

CONVERSATIONAL THERAPY AND SYSTEMIC FUNCTIONAL LINGUISTICS

There is a small body of work explicitly using the approach of Systemic Functional Linguistics (SFL) (Halliday & Matthiessen 2004) to study therapeutic practice. SFL is a highly-detailed descriptive method for analysing language processes, and therefore an effective tool for describing the language people are using, and tracking language change. Researchers have attempted to use tools developed in SFL to track change in the language produced over time by people consulting therapists as a way of measuring the effectiveness of that therapy (Meares et al. 2005). This collaborative work between linguists and clinicians builds on his clinical use of figurative language, particularly metaphor, within the practice of conversational therapy:

> Language is an important determinant of which components of an affective response will be differentially perceived and communicated in a particular culture. For a language of affects to develop beyond the bodily, metaphor is required (Meares 2005, p. 92).

Echoing Peplau's (1952/1988) insistence on the importance of attending to the person's exact words, Meares (2005, p. 176) articulated the acuity practitioners need to employ in listening in order to identify the key aspects of language that may be developed for therapeutic effect:

> By listening, in a particular way, to the exact words and the way that they are used, one may begin to be able to use words that are repeated, words that seem unusually loaded, or words that have a peculiar ring to them, as a means of entering into previously unexplored areas of psychic life. A particular word or phrase may contain within it a "micro-history" that can be fleshed out and enlarged, and, in some cases, illuminate a much larger area of the individual's ordinary existence.

Other researchers in the field have investigated whether observed changes in patterns of language production correlate to actual changes in well-being or behaviour, but they have not yet reached conclusive answers (Henderson-Brooks 2010; Muntigl 2004).

Fine, a linguist working in the discipline SFL, published *Language in psychiatry: a handbook of clinical practice* (2006) as a primer for clinicians interested in developing their knowledge about language to improve their clinical practice. Rather than drawing examples of language used in clinical practice empirically, Fine himself constructed a short passage of text, and then imaginatively rewrote it in different ways, ostensibly to demonstrate different language practices that may occur subsequent to different mental health conditions. The resulting written constructions bear little resemblance to the language clinicians actually encounter in their work.

PSYCHOLINGUISTICS AND NEUROLINGUISTICS

Observations about language and the mental processes that underpin its use in both typical and atypical ways form the basis of modern experimental approaches.

> Psycholinguistics is the subfield of linguistics whose goal is to discover the psychological principles that underlie the ability of humans to comprehend, produce and acquire language (Akmajian et al. 2010, p. 595).

Like Jakobson (1956/1987) these researchers frequently undertake research into problematic use of language as a way to understand the fundamental processes of language. The more recent sub-discipline of neurolinguistics narrows the field of study further:

> Neurolinguistics studies the relation of language and communication to different aspects of brain function, in other words it tries to explore how the brain understands and produces language and communication (Ahlsen 2006, p. 3).

Within these disciplines, researchers have examined both processing of figurative language, and language and mental illness, with the former studies primarily addressing metaphor, and the latter predominantly focused on schizophrenia.

Gibbs (2007c, p. 23) noticed the relative lack of attention to metonymy paid by psycholinguists compared to metaphor, and asked:

> Is there a reason for psycholinguists' failure to study conceptual metonymies in figurative meaning construction, despite the prominence of work by cognitive linguists such as Panther demonstrating the salience of metonymy in many aspects of utterance interpretation? One difficulty in experimentally testing for the presence of conceptual metonymies during utterance interpretation is that these presumably entrenched knowledge structures are rather abstract.

Current psycholinguistic research makes mention of the attention to metonymic speech production in early psychiatric writing (Cameron 1944, Goldstein 1944), but this has generally not translated into its incorporation into experimental designs, perhaps for the reasons suggested by Gibbs (2007c).

A recent exception is the work of Rapp and colleagues (2008; 2011). They presented the results of a study in which people diagnosed with schizophrenia and a control group each had to interpret short sentences with literal, metonymic and nonsense meanings, and determine if the meaning were acceptable or not. They reported that people with schizophrenia made more errors in correctly attributing acceptability to metonymic sentences (Rapp et al. 2008).[3] They subsequently repeated the reading exercise with a group of 14 people without any known history (including familial) of mental illness, and monitored the responses using functional Magnetic Resonance Imaging (fMRI) technology (Rapp et al. 2011). They reported that the region of the brain most notably activated when subjects were interpreting metonymies is a region associated with the integration of world knowledge with linguistic knowledge. They also reported that subjects rated metonymically generated meanings as less acceptable than literal ones, and that subjects demonstrated a great deal of variation in their acceptance ratings for metonymic sentences. The authors reported a possible explanation for this variation was the context-free single sentence paradigm they used in their experiments. They report they plan to repeat the experiment with a group of people diagnosed with schizophrenia, but to date, no results of this research have been published.

Kuperberg, a key figure in the psycholinguistic study of schizophrenia, has published extensively, producing both overviews and original research (Kuperberg 2010a, 2010b; Kuperberg & Caplan 2003). Kuperberg (2010b, p. 590) posed the ‘What can psycholinguistics bring to the study of schizophrenia…and vice versa?’ Her research is focused on a technique involving the observation of Event Related Potentials (ERPs), which show differential electrical activity in response to predicted and incongruous words used in sample sentences (see, e.g. Kuperberg, Kreher & Ditman 2009). These are investigated to, ’explore the relationship between semantic and syntactic processing’ (Kuperberg 2010b, p. 593), picking up on the idea of semantic priming initially suggested by Bleuler (1911/1950). They have demonstrated that some people with schizophrenia exhibit different levels of electrical activity to controls in speech comprehension exercises. The authors speculate that their research subjects have

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[3] This study has only been published as an abstract from the proceedings of the 1st International Schizophrenia Research Society Conference.

problems in combining information from semantic memory with information in the immediate context, specifically an overreliance on semantic association that can lead to communication failures (Kuperberg 2010b). This work is providing experimental evidence for theories put forward by earlier researchers (Bleuler 1911/1950; Chapman 1960; Rochester & Martin 1979).

Kuperberg (2010b, p. 594) also noted a key assumption that underpins the neurolinguistic approach:

> A related question is how an over-reliance on stored semantic associations affects language *production*, which is how thought disorder is clinically assessed and quantified. To date, the types of psycholinguistic paradigms used to study schizophrenia have all measured language comprehension. The underlying assumption has been that these comprehension studies tap into the same semantic associative abnormalities that affect production. However, there has been little work testing this assumption.

Another key problem this research faces is the gap between language as used under experimental conditions, and language used in actual pragmatic exchanges. Kuperberg and Caplan (2003, p. 451) note:

> In one study using this paradigm, at least 70% of responses by both patients and controls that were judged to be pathologic based on the word-association test alone became meaningful in the context of sentences.

This demonstrates that an inference that had been made by a researcher that the language used was pathological was not supported when the context for the language use was taken into account. This echoes examples from earlier researchers (see e.g. Chapman 1960; Goldstein 1944) where the context, or more specifically the decontextualisation of language, influences the inferences that are based upon it.

A further limitation in this work is related to the narrow view of linguistics it adopts. Kuperberg (2010a, p. 599) states that ‘traditional linguistic models have generally regarded language as an insular system composed of its own sets of unique representations and processes’, though this in fact describes one approach to language, Chomsky’s Generative Grammar, which is a contested model (Harris 1993). Moreover, Kuperberg (2010a, p. 599) reports that concurrent work in her laboratory:

> …suggests that the comprehension of simple visual events may engage some of the same types of neurocognitive mechanisms as those which mediate language comprehension.

This suggestion aligns with the view of language and its place in broader cognitive processes posited by cognitive linguists, however, Kuperberg makes no mention of any of the authors associated with this approach.

Another psycholinguistic approach to the study of language and mental illness draws on the theory of mind. Originating in primatology, but soon developed in human studies, theory of mind holds that in order to communicate effectively, particularly in correctly interpreting inferences from another's speech, a person must have the capacity to recognise that the other person has their own mind and intentions (Brune 2005). Researchers have explored the idea that this theory of mind is impaired in people with schizophrenia, using comprehension tests that require participants to read short stories and correctly determine if characters in the stories hold false beliefs (Champagne-Lavau & Stip 2010). They report a correlation between theory of mind deficits and problems with pragmatic inferencing, which they suggest need further investigation using fMRI techniques.

A third psycholinguistic approach involves the investigation of correlation between speech disorder in people with schizophrenia, and specific failures in communication. Docherty (2012) noted that, while it makes intuitive sense that neuropsychological deficits and speech disorder are correlated, there is no robust evidence of specific relationships. Docherty recorded interviews with people with schizophrenia who had been asked to talk about themselves for ten minutes. Using a battery of analytic tools, including the Thought, Language and Communication Scale (Andreasen 1979a), Docherty (2012, p. 1333) reported her provisional conclusions, accompanied by a caveat and a restatement of the intent behind this work:

> Communication failures in the speech of schizophrenic patients may not reflect psychotic ideation so much as they reflect combinations of schizophrenia-related neuropsychological impairments. That being said, the majority of the variance in schizophrenic speech disorder is still unexplained. In the interests of developing interventions to ameliorate speech disorder, it would be very helpful to have a fuller understanding of its causes.

Other studies report similar constraints. In her summary of current psycholinguistic research in schizophrenia Kuperberg (2010b, p. 595) states, 'These ideas are fairly speculative'. The editors of a new journal devoted to cognitive research in schizophrenia, also state that their field, like much neuroscience, reports provisional knowledge of the relationship between the brain and the clinical manifestations of the disorder (Green & Harvey 2014).

Reflecting the provisional results of much of this research, there have been few attempts to translate findings into therapeutic interventions. This echoes the lack of research into integrating language into cognitive remediation reported above in the section, the Delivery of treatment.

NARRATIVE THERAPY

The work of the late Michael White and his colleagues is known as narrative therapy, or narrative practice. The name and the approach originate in the metaphor that life can be told as a narrative. This metaphor carries metonymic entailments, critically, that a person can assume the role of 'author' of their lives, and select which aspects will be given attention.

White cited select works from the early history of psychology (James 1890/1950; Vygotsky & Kozulin 1934/1986), to inform his ideas, but also drew on a much broader range of disciplines to develop his theory, including sociology (Goffman 1968), literary theory (Bruner 1990) and anthropology (Geertz 1973). He also integrated the philosophy of Foucault (1980), particularly his work on the operations of modern power, into his approach:

> We have a special responsibility to consider the ways in which we may have unwittingly reproduced assumptions about life and identity that are disqualifying of diversity in people's acts of living, and the ways in which we may have inadvertently colluded with the power relations of local culture. Continually questioning the metaphors we support in therapeutic conversations is part of this special responsibility (White 2007, p. 31).

White clearly states the responsibility therapists have to consider their language choices so as not to unwittingly reduce the recognition of the actions people already undertake in their own lives. White frequently used metaphor in his therapeutic work and his teaching. He spoke of providing 'scaffolding' to support people safely while they engaged in rebuilding their lives. He also spoke of ensuring people had an 'island of safety' before they embarked on difficult encounters, and expanded the entailments of the phrase, through 'peninsula' to 'continents of safety'. He responded to criticisms of people who challenged his use of combat metaphors, stating that while he never introduced these particular metaphors into therapeutic conversations, he respected the choices of people who viewed themselves as ‘fighting for their lives’ to employ such terms, and would work with these metaphors with them for as long as they were useful.

He challenged metaphors deeply embedded in Western culture, such as the idea of ‘human nature’ as fixed, immutable and explanatory, and identified the typical consequence in terms of the opportunities that are available for people who are experiencing problems:

> When human action is assumed to be a manifestation of some element or essence of a self that is determined by human nature, or by a distortion of human nature, it is rare for people to be invited to reflect on their lives in a way that allows them to determine what certain events might say about what is important to them (White 2007, p. 53).

White (2007) utilised the metaphor that life can be told as a story to create spaces where people can reflect on their lives. In doing so, he capitalised on the ways in which stories are not fixed, drawing on earlier theories of narrative:

> The world is full of partial stories that run parallel to one another, beginning and ending at odd times. They mutually interlace and interfere at points, but we cannot unify them completely in our minds. In following your life-history, I must temporarily turn my attention from my own. Even a biographer of twins would have to press them alternately upon his reader's attention (James 1907/1987, p. 548).

White (2007) spoke of people presenting with ‘problem-soaked narratives’, in which the problem they were dealing with had become completely entwined with their sense of self or identity, sometimes with the collusion of others, including family members and mental health workers. A characteristic of these narratives was that they would include any and all information that contributed to the sense of the person themselves as the problem, and at the same time, ‘edit out’ information which did not support this view.

Starting from the phrase ‘unique outcomes’ borrowed from Goffman (1968), White (2007) mapped out a process for helping people to separate from totalising identity descriptions. Called externalising conversations, he would start by encouraging a person to think of an instance when they didn’t wholly embody the problem position. From this point, he would ask them to expand on elements that contributed to the ‘unique outcome’, and slowly build up a picture of the person existing outside the problem definition they had occupied. The first step in these conversations is, ‘Negotiating a particular, experience-near definition of the problem’ (White 2007, p. 40).

The first word is ‘negotiation’, which signifies that the therapist supports the person to develop such a definition of the problem. ‘Experience-near definition’ encourages the person to describe what actually happens, rather than using general, underspecific terms. In cognitive linguistic terms, this is language that does not function through indirect reference, for example, metonymy. He states the intended outcome of this approach:

> In the context of externalising conversations, the problem ceases to represent the “truth” about people’s identities, and options for successful problem resolution suddenly become visible and accessible (White 2007, p. 9).

The links between narrative therapy and metonymy will be addressed in more detail within Chapter 3: Metonymy.

Language and identity as experienced by people who live with mental illness

What is often elided in the research history on language and mental illness is information about the experience of language by people who live with mental illness. There is a small body of knowledge about what it is like to be labelled with a mental health diagnosis. This comes from the literature of first-person accounts (see, e.g. Barnes & Berke 1971).

Barham and Hayward (1991) published a book length study *From the mental patient to the person* based on semi-structured interviews with 24 people with schizophrenia who were living in the community after experiencing lengthy periods in psychiatric hospitals. The book includes excerpts from the interviews, and the analysis highlights a number of themes that are relevant to this study, including the reconstruction of personal identity after psychosis, the experience of stigma, and positive and negative encounters with mental health workers. Much of this is reported in the participants’ own words, and the authors are careful not to erase contradictions, dilute harsh appraisals or edit out the humour in their accounts. In their discussion, the authors describe the two constructions of identity that people who live with mental illness in the community contend with, one in which their personhood is foregrounded, and the other in which their status as mental patient is placed as the salient attribute:

> Though bracketed, the category ‘mental patient’ is none the less still active and the P (mp) [Person (mental patient)] predicament may be seen to identify the structurally and culturally unresolved character of the terms of membership and participation available to people with mental illness in social life.
>
> The relevant contrast is with what we may characterise as the Mental Patient (person) predicament of MP (p) in which the person comes to be defined in his or her illness and the category of the person is bracketed but not necessarily abolished (Barham & Hayward 1991, p. 144).

They suggest that the P (mp) predicament potentially offers a means to move beyond being identified primarily through the experience of mental illness, but note, ‘from the testimonies of our participants…it is clear that the accent here is very much on the potential’ (Barham & Hayward 1991, p. 144). The conceptualisation, and the notation in which they express it, illustrate the operation of metonymy, with inferences following from which element, the person or the illness, is foregrounded.

More recently, the Scottish Recovery Network has collected a significant number of narratives of recovery from mental illness, and published them on the internet. These stories have use in and of themselves, as reading other people’s descriptions of their experiences has been reported as helpful. A selection from the narratives has been subjected to analysis, with a focus on identifying which processes people with mental illness engage with support them in their recovery (Brown & Kandirikirira 2007). Metonymic language is not explicitly mentioned, but its influence is evident in the descriptions of identity; for some participants, forming identity based on having a mental health diagnosis was reported as helpful in giving them a sense of community and connection when dealing with an otherwise isolating experience.

The mental health consumer movement is creating a space where people can talk about their experience, frequently in online social media in the form of webpages, blogs and twitter accounts. Some of these include robust discussion of language use, for instance, critiques of language used about people who live with mental illness that appear in the media or in policy documents (see, e.g. Epstein n.d.; Webb n.d.).

One of the most prominent Australians with lived experience of mental illness is Janet Meagher, who recently completed a term as one of the inaugural National Mental Health Commissioners. Meagher (2014, p. 8) firmly positions the significance of her experience of mental illness within her overall sense of self:

> I have accepted schizophrenia and no longer deal with it as a problem needing to be 'treated' or eliminated, but as a 'normal' aspect of me that merely needs to be managed and monitored by me. This mindset is hard to practise and learn but makes for a great quality of life and the ability to reach some of my remaining potential.

Meagher's (2014) comment, that dealing with schizophrenia as a normal part of oneself is hard, reflects clinical and research discourses that address the condition through the lens of impairment. Her assessment of the contribution of this practice to her quality of life suggests the benefits of applying rigorous method to an alternate view, developed through her lived experience and that of others who live with mental illness.

STIGMA

The experience of stigma, frequently expressed through language, is widely reported by people who live with mental illness (Brown & Kandirikirira 2007; National Mental Health Commission 2012; Reavley & Jorm 2011). Stigmatising attitudes voiced and enacted by clinicians have been reported toward people who live with mental illness (Hill 2010; Ross & Goldner 2009), and these have been associated with poorer outcomes through the process termed diagnostic overshadowing, where physical symptoms are either not recognised, or incorrectly attributed to mental illness (Shefer et al. 2014). Self-stigma, where stigmatising attitudes are internalised by people who live with mental illness themselves, has been associated with having greater insight into the illness (Lysaker, Roe & Yanos 2006), and is also linked to poorer outcomes (Corrigan, Kosyluk & Rusch 2013).

How stigma functions pragmatically has also been addressed by Thornicroft and colleagues (2007, p. 192), who state that:

> Stigma can therefore be seen as an overarching term that contains three elements: problems of knowledge (ignorance), problems of attitudes (prejudice), and problems of behaviour (discrimination).

They call for a shift in focus from attending to attitudes, for example, through population surveys (e.g. Reavley & Jorm 2011), to evidence of behaviour, for example, how many people with disability does your company actually employ?

The influence of metonymy on the practice and experience of stigma is considered in more detail below in Chapter 3: Metonymy, in the section 'Labelling theory and stigma'.

Conclusion

The critical role played by language in the assessment of and therapeutic approaches to mental illness has been a subject of research from the beginning of modern psychiatry. Clinical decisions that are made, based on assessment of a person's use of language, carry considerable diagnostic and medico-legal implications. Yet both research and clinical practice have frequently been characterised by received and conventional views about language that do not reflect the complexities of language and communication explored within linguistics. Conversely, therapeutic approaches that do focus on careful use of language in order to create opportunities for people to participate in their own recovery (e.g. Meares 2005; White 2007), do not demonstrate attention to the specific illness-related communication problems that people with mental illness may experience. 'Illness narratives' have traditionally run the risk of being dismissed as merely anecdotal and peripheral to the type of research that should inform health practice (Bury 2001). Blogs are considered to be unreliable sources for the purpose of research.

Previous studies have considered unusual patterns of language use as a tool to assist with differential diagnosis of mental illness in the clinical setting (Andreasen 1979a; Chapman 1960). Contemporary psycholinguistics and neurolinguistics elicit examples of language use under experimental conditions in order to locate areas of the brain involved in language processing, and speculate on aetiological causes of language dysfunction (Crow 2010; Kuperberg & Caplan 2003). First person accounts of mental illness broadly discuss what it is like to live with mental illness, recounting clinical and social events that have shaped their experience (Barnes & Berke 1971; Brown & Kandirikirira 2007).

This study is designed to reflect the complexity of the topic, as it is expressed through the language of people living with mental illness. The next chapter gives a more detailed background to one aspect of language, metonymy.

CHAPTER 3: METONYMY

This chapter is a review of metonymy as it has been discussed, initially within rhetoric, and more recently in cognitive linguistics. At a basic pragmatic level, metonymy is a case whereby a speaker says one thing, but means another. As a communication strategy, a speaker using metonymic language relies on confidence that, in the context, the hearer will be able to infer the intended meaning rather than the literal one.

Earlier definitions

The word metonymy originates from the Greek '*metonymia'* from 'meta', after or beyond, and 'onymia' a suffix used to name figures of speech, from 'onoma', name. This is usually abbreviated to meaning 'change of name'. As such, it is not specific, as the same definition could be used for other figures of speech, including metaphor. It was considered an aspect of rhetoric, or the art of persuasion using words, and therefore treated with some suspicion; an educated person should be aware of it in order not to be manipulated in their thinking (Ricoeur 1975/2003).

Further refinement of this figure of speech was taken up by Latin rhetoricians:

> Quintilian lists the kinds usually named: container for thing contained ("I'll have a glass"); agent for act, product, or object possessed ("reading Wordsworth"); cause for effect; time or place for their characteristics ("a bloody decade"); associated object for its possessor or user ("the crown" for the king) (Preminger, Warnke & Hardison 1986, parentheses in original).

Within rhetoric, figures of speech were considered to contribute to the style of one's language, and able to be modified to achieve different ends. As rhetoric declined, tropes, or figures of speech, were relegated to poetics, and style treated as ornamentation for literary purposes. Ricoeur (1975/2003, p. 10) comments that, 'Before becoming futile, rhetoric was dangerous'. It is ironic that the one discourse in which metonymy is still frequently and deliberately used is advertising, in which communication is explicitly designed to persuade people to make choices they may not otherwise make.

It is the traditional definition of metonymy, as a figure of referential substitution, that Cameron (1944) and Goldstein (1944) used in describing how metonymic speech featured in their clinical population. However, rather than a deliberate linguistic strategy used to influence communication, they posit its use as pathological and obscuring meaning.

JAKOBSON

Jakobson, a Russian linguist, published an article, *Two aspects of language and two types of aphasic disturbance* (1956/1987), which offered a radical reinterpretation of the relation of metonymy and metaphor. Jakobson describes language as consisting of two processes, the selection of terms from the range of possibilities and their combination into phrases and sentences. Jakobson observed two distinct patterns of dysfunction in the speech production of people with aphasia, difficulty in selecting terms and difficulty in combining them. From these observations, Jakobson posited two poles of speech, the metaphoric and the metonymic poles. In Jakobson's view, metaphor relates to the process of selecting a reference for something, a relatively unconstrained process. Metonymy relates to the combination of selected terms into coherent structures, and is therefore more subject to constraint. Though he did not undertake empirical research into this phenomenon Jakobson (1956/1987, p. 110) stated that:

> In normal verbal behaviour both processes are continually operative, but careful observation will reveal that under the influence of a cultural pattern, personality, and verbal style, preference is given to one of the two processes over the other.

Jakobson's (1956/1987) radical departure from traditional views of the function of each of these figures of speech, metaphor and metonymy, has been both influential and controversial. The elevation of metonymy to a standing equivalent to metaphor, and the suggestion that 'in normal verbal behaviour both processes are continually operative' prefigure the cognitive linguistic approach of viewing these figures not just as ornaments, but as part of 'everyday speech'. The association of metonymy with the combinational aspect of language has largely been abandoned in subsequent linguistic research, but was taken up by French structuralists, in interpreting topics in disciplines such as semiotics (see e.g. Barthes 1994) and psychoanalysis, in which Lacan (2006) suggested that the unconscious is structured like a language. Jakobson's (1956/1987) ideas about the potential function of metonymy, particularly in everyday language, would be most fully explored within cognitive linguistics.

Cognitive linguistic definitions

Cognitive linguistics is an approach that considers language as one cognitive process among other cognitive processes, including attention, problem-solving, and categorisation (Geeraerts & Cuyckens 2007). By directly addressing cognitive and conceptual processes, cognitive linguistics is ideally suited to considering language as it operates in psychological states. That said, it has been minimally used for this purpose. One of the core principles of cognitive linguistics was noted to be that linguistic meaning is encyclopaedic and non-autonomous (Geeraerts 2008). Langacker (2007, p. 432) expands on the pragmatic implications of this concept:

> On the encyclopedic view, a lexical item provides a particular way of accessing associated domains of knowledge. The access it affords is flexible and subject to contextual influence, but not at all random or unconstrained.

It is this capacity to activate one out of a range of possible meanings that allows listeners to infer the correct meaning intended by the speaker, by using the context of the speech event, the preceding language (sometimes specified as the cotext) and their real world knowledge. A key element in this process is the role played by constraint, without which an intended meaning could not be conveyed.

Within cognitive linguistics, attention to metonymy has developed as a key focal area for the discipline. Being a subject of attention in a burgeoning discipline does not guarantee agreement among scholars. Defining metonymy in cognitive linguistic terms remains controversial (see e.g. Benczes, Barcelona & Ruiz de Menoza Ibanez 2011; Croft 2006; Peirsman & Geeraerts 2006a, 2006b). This demonstrates the prescience of earlier commentators:

> In seeking a logic underlying metonymy and other tropes, theorists are forced to redefine them, reassigning some of the examples they traditionally include to other tropes, and discarding others. In so doing, they define the tropes stipulatively, or figuratively (Preminger, Warnke & Hardison 1986).

An early formulation comes from the book recognised by many as the seminal text in cognitive linguistics, *Metaphors We Live By*:

> In these cases, as in the other cases of metonymy, one entity is being used to refer to another...But metonymy is not merely a referential device. It also serves the function of providing understanding (Lakoff & Johnson 1980, p. 36).

This recalls the etymological definition of metonymy in its under-specificity, and again fails to distinguish metonymy from metaphor and other figures of speech. As the title suggests, the authors are not yet ready to grant metonymy equivalent attention as metaphor. Nonetheless, it is a statement of a role for metonymy in language, including everyday speech, which takes it beyond simple ideas of referential substitution.

The difference between metonymy and metaphor is a topic of longstanding controversy. One proposal is that in metaphor, the source and target are linked by similarity, whereas in metonymy, they are linked by association. A simple test has been used to differentiate the figures: in metaphor, the source 'is like' the target, in metonymy, the source 'stands for' the target. For instance, it can be said that, 'a man is like a lion', but not, 'a man stands for a lion', therefore this is a metaphor. Or it can be said, 'the Crown stands for the monarchy', but not, 'the Crown is like the monarchy', and therefore this is a metonym. Cognitive linguists have suggested that in metaphor, the source and the target exist in different conceptual domains, but in metonymy, they exist in the same conceptual domain. The distinction remains controversial (Croft 2006; Peirsman & Geeraerts 2006a, 2006b).

Lakoff studied metonymy further in his book *Women, Fire and Dangerous Things.* Following on from Rosch's work on categorisation (Rosch 1978), he explored ways in which categories could include members which stand as prototypes, as well as more peripheral members:

> A cognitive model may function to allow a salient example to stand metonymically for a whole category (Lakoff 1987, p. 90).

This metonymic process can have significant influence, as when the category as a whole is invoked, the salient prototype occupies the foreground, relegating peripheral members to the background.

Cognitive linguistic work on metonymy accelerated in the 1990s, and a definition formulated toward the end of the decade has been widely used since then:

> Metonymy is a cognitive process in which one conceptual entity, the vehicle, provides mental access to another conceptual entity, the target, within the same idealized cognitive model (Radden & Kovecses 1999, p. 21).

However, there are a number of problems with this definition. It relies on a specific concept unique to cognitive linguistics, the idealised cognitive model, or ICM (Lakoff

1987). Lakoff proposes that 'we organize our knowledge by means of structures called idealized cognitive models' (1987, p. 68), and that:

> Each ICM is a complex structure whole, a gestalt, which uses four kinds of structuring principles: propositional structure…image-schematic structure…metaphoric mappings…[and] metonymic mappings (1987, p. 68).

Littlemore (2015, p. 12) expands on the role and development of ICMs:

> The best way to describe them is as a series of embodied, encyclopaedic, loosely connected and somewhat idiosyncratic knowledge networks that we have in our minds. But how do they get there? The explanation usually given is that ICMs build up gradually over time as a result of our interactions with the world and the people in the world. In other words, they are largely 'usage-based'.

While influential, the term is not agreed to by all within cognitive linguistics, and is not broadly recognised outside the field. Critics have focused on problems with defining the borders of an ICM, which renders a definition reliant on the process occurring 'within' this border somewhat tenuous (Feyaerts 2000).

An important aspect of the cognitive linguistic approach to metonymy is that it offers insights into the cognitive motivation for using metonymy in the first place. These centre round the ideas of economy and optimalisation:

> In order to identify a certain referent, make use of a feature that economically allows for the unique identification of that referent in the given context (Geeraerts & Peirsman 2011, p. 96).

Economy of language use was most famously addressed by H. Paul Grice, a philosopher of language who has had a major influence on the development of the pragmatic approach to linguistics. Grice (1975, p. 45) stated a number of maxims that govern how conversation is understood, including the maxim of quantity:

> Make your contribution as informative as is required (for the current purposes of the exchange),
> Do not make your contribution more informative than is required.

When the 'current purposes of the exchange' are well-known to both speaker and hearer, short cuts can be taken that fulfil the second part of the maxim, that is, do not provide more information than is required, while still comprising effective communication. Metonymic usage contributes to this economy. A term may appear underspecific to an outsider, but function pragmatically in context.

Langacker (2009, pp. 44-5) addresses the discrepancy between source and target (here called profile/active zone), and pragmatically inferred meaning:

> We easily manage the imprecision and indeterminacy inherent in profile/active zone discrepancy. In fact, we do not even notice it. The reason is that we are able to make sense of discrepant expressions by exploiting general knowledge…But why does profile/active zone discrepancy occur in the first place? It is actually both natural and often necessary from the cognitive standpoint. In many cases complete precision and accuracy in describing a relational participant is simply not possible. Discrepant expressions are natural because they profile, and thus make linguistically prominent, entities that have greater cognitive salience.

Key elements to note are that indeterminacy frequently goes unnoticed, and that complete accuracy in expression is neither possible nor necessarily desirable. At the same time, it is the combination of indeterminacy, and the fact that indeterminacy can go unnoticed that can lead to problems in the influence of language in mental health practice, especially when the lack of noticing occurs in contexts of power imbalance.

A WORKING DEFINITION

The definition of metonymy with the best fit for this project comes from a recent collection, *Defining Metonymy in Cognitive Linguistics: Towards a consensus view* (Barcelona 2011). The book is a collection of papers from a conference that shared the aim made explicit in the title. The book itself demonstrates a lack of consensus, which early critics have noted, nonetheless, it yields at least one definition that solves some of the earlier problems:

> Metonymy is an asymmetric mapping of a conceptual domain, the source, onto another domain, the target. Source and target are in the same functional domain and are linked by a pragmatic function, so that the target is mentally activated (Barcelona 2011, p. 52).

In this definition, the key concepts of target and source, mapping, asymmetry, functional domain, pragmatic function and activation are useful in explaining metonymy, especially in relation to its differentiation from metaphor.

TARGET AND SOURCE[4]

The target is the intended meaning of an utterance. The source is the term selected to suggest this target. Thus, when a nurse refers to ‘bed 15’, the intention is that a colleague will understand they are referring to the person currently occupying bed 15; the target is the person, and the source is their bed number. This raises a very important aspect of metonymy: its dependence on contingency. In this example, the person (the target) can only be effectively referred to by this bed number (the source) while they are in it. Should they leave hospital, it will be meaningless to call them bed 15. Should they move to another bed in the unit, and somebody else occupy bed 15, that new incumbent is the only one who can be effectively referred to in this way, indeed it would be incorrect, perhaps catastrophically, to retain the initial source to refer to the previous target. Authors have associated the contingent aspect of metonymy with its use being accidental, as opposed to necessary (De Man 1979), or defeasible (Panther & Thornburg 2007).

Another critical factor about the relationship between source and target for this study is that when a source term is used, even if the intended target is successfully understood by the listener in the context, elements of the source meaning are also mentally activated. This plays a key role in the creation of inference, or the more subtle nuancing of a message. For example, when a nurse refers to a person as ‘bed 15’, their colleague may immediately and correctly understand which person is meant, but a message that all of the people who occupy the beds are interchangeable has also been made available. Brdar-Szabo and Brdar (2011, p. 236) have referred to this as, ‘an efficient way of saying two things for the price of one’. It is possible for these secondary meanings to be intentional, correctly inferred, welcomed or disavowed by different speakers and listeners, and this is a key aspect in metonymy’s discursive power.

MAPPING

Mapping itself relies on a metaphor, that three-dimensional space can be represented two-dimensionally, and that there are conventions to this representation. The purpose of a map is to enable communication of information in economic means, to serve a specific function. If a traveller can make their way safely through a landscape without having to carry a three-dimensional model, their passage will be more efficient. Using this metaphor to describe communication, the fewer words one needs to be understood in a specific context, the more efficient the communication will be. For the map user, as

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[4] Other terms that have been used to denote the Target/Source dyad are Tenor/Vehicle (Richards 1991), trajector/landmark (Langacker 1993), and profile/active zone (Langacker 2009).

for speakers and hearers, understanding of, and concordance with the conventions is necessary for the process to work.

Mapping also invokes traditional ‘common-sense’ views of language, most particularly that there are things and concepts in the world, and that words name these, in a straightforward manner. It is this view which prevails among many language-users, but that has been comprehensively refuted by linguists.

> Mappings become culturally and lexically entrenched, and as Turner (1991) shows, they actually define the category structure for the language and culture. Rather remarkably, although the vocabulary often makes the mapping transparent, we are typically not conscious of the mapping during use, and in fact are liable to be surprised and amused when it is pointed out to us (Fauconnier 1997, p. 9).

This observation states another aspect of the concept that language choices may be conscious or unconscious.

ASYMMETRY

The reference to asymmetry denotes that in metonymy, it is usually one attribute that is selected for highlighting. Another term used to describe this is ‘foregrounding’. It is this selection of an attribute for highlighting that functions pragmatically to suggest what inference is to be understood.

Asymmetry contributes to distinguishing metonymy from metaphor, the latter being considered to map symmetrically. When a concept is mapped metaphorically, conceptual entailments tend to follow. For example, in the metaphor ‘love is a journey’, a whole array of ideas can be transferred, people can be understood to be at a crossroads, travelling hard, on the rocks, or in for a bumpy ride (Lakoff 1987). When metonymy is used, this does not occur automatically, though some authors have pointed out that metonymies can be linked in chains, to support coherence and build inferences (Brdar-Szabo & Brdar 2011).

FUNCTIONAL DOMAIN

Functional domain replaces ICM from the earlier definition (Radden & Kovecses 1999), and is more readily understood outside cognitive linguistics. A functional domain describes the context in which speech occurs. A familiar functional domain is a hospital ward. There is a broadly understood function in each specific ward, and this provides a baseline context. Certain aspects of a functional domain may be transferable across units, for example, referring to people by their bed numbers, but others may not be recognisable one floor up, for example, ‘CABG’ (Coronary Artery Bypass Graft, pronounced ‘cabbage’ in cardiac inpatient units), which is only going to be familiar to specialist cardiac teams. Slippage in metonymic referencing explains the ongoing and unresolved notion of what to call a person who receives health care in different settings. Having left hospital, a person may no longer consider themselves to be a patient, with its connotations of passivity. A doctor may unconsciously wish to foreground their role as expert in continuing to refer to the person as their patient. Many opt for consumer, as connoting the person’s consumption of service, and this connotes choice, even when the person may have no choice at all about receiving service, for example, when they are legally constrained to accept treatment.

PRAGMATIC FUNCTION

Pragmatic function refers to how language actually works. It is less about the rules of language, covered in semantics and grammar, than how language is effective in real communication. For the purpose of this study, the pragmatic elements of particular importance involve inferencing, that is, how the speaker’s intended meaning is understood by the listener in the specific context. This can involve correctly interpreting an indirect reference (metonymy), or presuming information not explicitly stated (ellipsis).

ACTIVATION

The final part of the definition to note is the idea of activation. This is more than simply referring. Words can carry a number of meanings, and language is processed ‘online’, having been primed by the context. A classic example is ‘bank’: the sentence, ‘I have to get to the bank before five’, will most readily be understood as referring to a financial institution. However, if you are in a boat, you will understand the term is referring to the bank of a river, without first having to process and reject the more common use of the term. This process depends on context to determine which particular meaning is salient (Giora 2003). Thus, use of the bed number on a ward will activate the concept of the person occupying the bed. Of course it is possible that it is the bed itself that is being directly referred to, for example, when someone is being enjoined to clean it, but again, context will constrain which aspect is activated. Psycholinguistic research has confirmed that native speakers of a language need no more time to process figurative language than literal language (Gibbs & Colston 2006).

Activation relates to asymmetric mapping and inference:

> Metonymy-driven re-conceptualization can be relatively transient and limited... or it can leave an extensive permanent trace in cognitive domains and in inference patterns (Barcelona 2011, p. 13).

This concept is particularly pertinent in health settings. Some uses of metonymy can be completely contingent, for example, referral to person by bed number they happen to occupy on a particular day in a particular ward, and this will have only transient meaning. However, in health discourse, attribution based on diagnosis can leave 'an extensive permanent trace' (Barcelona 2011, p. 13).

Types of metonymy

Different authors have identified different subtypes of metonymy, based on the part of speech affected, and the pragmatic speech function of the process. Three subtypes are reviewed here as relevant to the thesis topic; referential, predicational and illocutionary metonymy.

REFERENTIAL METONYMY

Referential metonymy is the prototypical form of metonymy, in which indirect reference is made to an object, entity or concept, through substitution of the name of something which is conceptually contiguous to that object. Frequently encountered referential metonymies included the substitution of a part for a whole, or a container for its contents.

PREDICATIONAL METONYMY

Predicational metonymy occurs when the transfer of meaning is in relation to properties of the object. The term is based in grammar, where a sentence is divided into a subject and a predicate, which carries information about the subject.[5]

Panther and Thornburg (2003a, p. 4) include predicational metonymy in their typology of the figure, and illustrate it as follows:

> An example of a predicational metonymy is 'General Motors had to stop production', where the necessity or obligation to stop production stands for the actually occurring event of stopping production (Obligation to act for action). The metonymy involved is an instance of a high-level metonymic principle that

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[5] Care must be taken not to confuse the conceptual use of the word 'object' in linguistics, and the grammatical use of the word, in which the 'object' is differentiated from the grammatical subject.

> is very common in English and other languages. A potential event (e.g. the ability, possibility, permission, obligation to undertake an action) is metonymically linked to its actual occurrence.

The difference between referential and predicational metonymy is most clearly described by Nunberg in his article ‘Transfers of Meaning’ (1995). He uses two examples of sentences a person could say when handing keys to a valet:

1. This is parked out back.
2. I am parked out back (Nunberg 1995, p. 110).

Both of these sentences involve metonymy. In example 1. ‘This’ indirectly refers to the car, which is not present, and the object which ‘This’ directly refers to is the key, which is linked to the car by contiguity, that is, the key is needed to start the car. The substitution that has occurred is in the reference to the object. In example 2. However, the person speaking does not stand for the car. The substitution that has occurred is at the level of the predicate, which describes a property of that person, in this instance, that their car is parked out the back. Again, there is a metonymic transfer that is salient in the context (handing keys to a valet), but it is at the predicational, rather than the referential level.

Predicational metonymy can be used as a short-cut to convey meaning, when attention is drawn to a property or attribute of an entity that it cannot literally possess, but which is readily understood. For instance, the University of Technology adopts the term ‘Ambulant toilet’, for which a literal reading is impossible, to signpost a toilet accessible to people who have difficulty ambulating. A prototypical examples of this type of metonymy is ‘healthy diet’, in which health, is posited as an attribute, rather than a result of a diet (Littlemore 2015). This technique is frequently used in advertising, which extends the metonymic links in terms such as ‘healthy floor’, in order to sell floor cleaners.

ILLOCUTIONARY METONYMY

Illocutionary metonymy is a form that demonstrates the intersection of cognitive linguistics with pragmatics, in particular speech act theory. Panther and Thornburg (2003a, p. 4) state:

> The basic idea is that an attribute of a speech act can stand for the speech act itself in the same way that an attribute of a person can stand for the person.

Consider the requests, ‘Can you close the window?’ or ‘I would like you to close the window’. These are examples of indirect requests, directed to another person, to close a window. But both carry information in addition to the direct request, which could simply be stated as ‘Please close the window’. The first also incorporates a predicational metonymy, where the person’s capacity to perform the act stands for them performing the act. The second includes information about how the act will affect the person requesting it. In both cases, the indirect request stands for the direct request. These are typical examples of the language practice known as hedging (Eggins & Slade 1997), where a person does not directly express their meaning, usually for external reasons. The process can extend further, for example, when a person further away from a window asks, ‘Don’t you think it’s cold in here?’ couching the request to close the window in even more indirect fashion.

Illocutionary metonymy creates space for a range of inferences, and subsequent responses, for example, a literal response, ‘yes’ or ‘no’ to the last question. These can be used for humorous effect. A person can follow someone else’s statement ascribing intent where it is unlikely. For example, when someone declines a second serve, ‘Don’t you like my cooking?’

There are a number of key elements from this discussion of metonymy from a cognitive linguistic perspective that are relevant to the current study. These include:

1. Metonymy is prevalent in all speech contexts, including everyday speech, and clinical encounters.
2. Metonymy is a conceptual process, not simply a linguistic substitution process.
3. Metonymy is valued because it allows for effective communication with efficient cognitive work.
4. The choice of source to activate target may influence the pragmatic inference that follows. This influence may be intentional or not.

These principles can be demonstrated through a consideration of how metonymy operates in nursing contexts.

Uses of metonymy in nursing contexts

Following Nunberg (1995), it is possible to see metonymy operating at the referential, predicational and illocutionary levels in typical mental health nursing language, even occurring concurrently. Consider the following examples:

1. My borderline needs some PRN.[6] (Nurse to colleague)
2. That borderline needs some PRN. (Nurse to colleague)
3. I need some PRN. (dispensed for my borderline) (Nurse to colleague)
4. I need some PRN. (charted for my borderline) (Nurse to doctor)
5. I need some PRN. (Nurse to colleague)

The first two cases demonstrate referential metonymy – both use attributes of a person that are salient in the ward context to refer to a person, in this case a diagnosis. Example one can also function as an illocutionary metonymy; dispensing PRN frequently necessitates a second nurse to countersign the medication chart, and so the statement made to a colleague can also stand for a request for the colleague to perform the requested action. Example 2 can also carry a range of pragmatic inferences. It may be a statement of clinical opinion, which again includes a presumed action in response. However, it may also be stated as an opinion by someone not involved in the person’s direct care, and carry an implicit negative inference about the care being delivered by the treating team.

Examples 3 and 4 demonstrate predicational metonymy, (note that I have also spelled out in parentheses the indirect object which would typically be elided in these exchanges). The nurse does not literally need the medication for themselves, so the transfer of meaning does not occur at the level of the subject, but rather at the predicate level, relating to a property of the indirect (and typically elided) object of the sentence, the person for whom the PRN is intended. Both of these sentences are likely to be uttered as written, but in fact, each has a different intent. Example 3 may be a statement, or also carry the same request as in example 1, and thus also be an illocutionary metonym. In example 4, metonymy, again at both the predicational and illocutionary levels, is combined with ellipsis. In this instance, the request is for the doctor to agree to chart medication for discretional use. The auxiliary verb ‘charted’ is elided, but understood.

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[6] ‘PRN’ stands for ‘*pro re nata’* or ‘as needed’ medication, which is charted by doctors for discretional use by nurses to dispense when they judge that routinely prescribed medication is inadequate to address the person’s distress. It is typically spoken as an acronym.

From this simple example, it is possible to see that complex pragmatic operations are occurring for these sentences to be correctly interpreted, yet all of this passes generally without notice, consistent with an observed characteristic of metonymy (Littlemore 2015). A fifth example, using the same words as examples 3 and 4, can be used ironically, ‘I need some PRN’ stated by a nurse heading to the pub at the end of their shift.

Just as metonymy can pass unnoticed in clinical practice, the actual term metonymy has figured very little in nursing and mental health nursing literature, but the concept has been addressed by several authors. Menzies Lyth (1959/1988, p. 166) observed metonymic language use by nurses in the 1950s, in her study of nursing attrition from a large teaching hospital in London, though she did not specifically use the term:

> For example, nurses often talked about patients not by name but by bed number or by disease or diseased organ: 'the liver in bed 10' or 'the pneumonia in bed 15.' Nurses themselves deprecated this practice, but it persisted. The implicit aim of such devices, which operated both structurally and culturally, may be described as depersonalization or elimination of individual distinctiveness in both nurse and patient.

Menzies Lyth (1959/1988) identified the linguistic practice as part of a suite of practices designed to distance nurses from the people for whom they cared. Other practices included dividing the nursing role into a number of separate tasks that would be completed by different nurses, and moving nurses between different wards frequently and with little notice. A member of the Tavistock Institute, using psychoanalytic methods to inform organisational studies, Menzies Lyth (1959/1988) reported that the intended aim of these strategies was to thus protect nurses from the anxiety generated by close contact with human suffering. She pointed out that, not only did the strategies not protect nurses from exposure to the suffering of others, it also prevented them from forming the kinds of attachments to patients that would enable them to process the resultant anxieties. Menzies Lyth (1959/1988) was explicit about the depersonalising influence of this metonymic naming practice, and its impact on both patients and nurses.

In contrast, Peplau (1952/1988, p. 124), writing a few years earlier, suggested a different potential outcome, if nurses were allowed to practise skills in managing the anxiety of the people they cared for:

> There is the possibility that the nurse will develop *skill in aiding the patient to undergo the discomfort and to utilize the energy provided by the anxiety in identifying and assessing the difficulties in the situation* (italics in original).

In this approach, anxiety is explicitly recognised, and seen as a source of energy within the interaction. Both approaches are echoed in contemporary nursing literature, including the influential Tidal model (Barker 2001), and approaches that recognise the emotional impact of nursing (Corley 2002; Freshwater & Stickley 2003).

Nursing provides an ideal context for micro-cultural language use. People encounter each other regularly in a circumscribed setting with shared goals and clear role designations. Nursing is often conducted in busy settings, increasing the privileging of economic communication. It is perhaps not surprising that examples of nursing language are used to illustrate metonymy in cognitive linguistic texts:

> So, when the nurse says '*The gastric ulcer in Room 12 would like some coffee'* (s)he is using the illness (the gastric ulcer) to identify the patient who has it (Fauconnier 1997, p. 11, italics and parentheses in original).
>
> The vasectomy/herniated disk in 304 needs a sleeping pill [one nurse to another in a hospital] (Langacker 1993, p. 29, brackets in original).

Health discourse provides an ideal example of ‘pragmatic function mapping’ (Fauconnier 1997, p. 11), bringing together key concepts including the importance of context, and the high value placed on economy of speech. The examples of nursing language cited by Menzies Lyth (1959/1988) and the cognitive linguists (Fauconnier 1997; Langacker 1993) are practically identical. It is one of the many examples of missed opportunities, where authors do not refer to relevant previous work, and theoretical possibilities are left unnoticed. The motivations underpinning metonymic language use that were analysed psychoanalytically by Menzies Lyth (1959/1988) strongly resonate with the kinds of cognitive processes identified decades later by the linguists, but they do not draw on her conclusions at all. The current study integrates knowledge from disparate disciplines.

Metonymic language can be used to promote economic information exchanges, particularly valuable when a clinical environment is busy. Nursing language richly illustrates the variety of attributes that can be selected by speakers for attention. A nurse on a busy unit may refer metonymically to a person being cared for by: bed number, ‘Bed 15’; diagnosis, ‘the cirrhosis in Bed 15’; secondary diagnosis, ‘the PLHIV’ (person living with human immunodeficiency virus); putative diagnosis, ‘just a P.D.’ (personality disorder); symptom, ‘Oh, you’re the two-day fever’; body part, ‘the kidney’; procedure, ‘I’ve got two ECTs this morning’ (for person undergoing Electro Convulsive Therapy); parents’ surname, ‘Baby Smith’; role, ‘Mum at bedside’ (reportedly documented regardless of gender of attending parent) (Crawford 2014); appointment time, ‘your 10.15 is getting toey’; or prosthesis, ‘the trachy’ (for person with a tracheostomy). It is likely that a colleague in the same context will correctly infer who is being referred to by any of these terms.

Beyond its contribution to fast and economic communication, routine metonymic language can contribute to the formation and maintenance of shared identity, and mastering the jargon can be a sign of cultural belonging for the novice practitioner. However, cognitive linguists are alert to the benefits and perils of metonymic indeterminacy:

> We sacrifice total reliability for the sake of speed and quantity. The price we pay includes prejudice and the occasional accident (Hudson 2007, p. 517).

While this is a statement about language use in general, there are implications for nursing. The prevalence of prejudice among nurses has been documented. (Hamilton & Manias 2006; Hill 2010; Ross & Goldner 2009). This prejudice can be enacted and reinforced by the language used within the culture of a ward. This can be observed in mental health practice, where nursing handover has been identified as a process in which inferences conveyed about the people receiving care through language can influence staff attitudes and the subsequent care that is delivered (Hamilton & Manias 2006). This is particularly the case with people who have been diagnosed with a personality disorder, often referred to using vocalised initials, ‘peedee’. The label can be applied to anyone whose behaviour nurses disapprove of, whether they have the formal diagnosis or not. A frequent use of the term is ‘Just a P.D.’, with the term ‘just’ highlighting the assessment that the person has no attributes beyond the putative diagnosis.

Midwives have challenged the language used around women and birth, often using humour to convey an important message about how paradigms influence the care that is provided, for instance by stating ‘Women give birth and pizzas are delivered’ (Hunter 2006). While metonymy is not explicitly mentioned, the examples of language given are metonymic. The implications of this are further examined in work addressing breastfeeding. Burns and colleagues (2012) demonstrate how, when midwives speak of facilitating breastfeeding as ‘mining for liquid gold’, they engage in practices that focus on the midwife getting the breastmilk into the infant, meanwhile reducing the new mothers to their breasts, or milk delivery units functioning successfully or not. This can include material practices such as handling women’s breasts without seeking permission. The language and the conceptualising of the process are metonymic.

An article by Arntfield (2008) casts an interesting light on the influence of the use of metonymic language by mental health nurses. Arntfield examined the operation of ‘shorthand’ in police communications, and how this leads to the maintenance of damaging stereotypes. Arntfield (2008) demonstrates how this shorthand is underpinned by metonymy. Both police and nurses are exposed to traumatic aspects of human experience, and workplace cultures are developed in part to manage the resultant anxiety. Within these cultures language choices are pragmatically motivated by the need for fast and economic communication, which metonymy supports. As a consequence, both professions must also contend with the implications of the ‘shorthand’ that results, including the reinforcing of stereotyping attitudes toward particular populations.

Metonymy and mental illness

At the outset of the present study, a search was undertaken for the terms ‘metonymy’ and ‘metonymic’ in key online database search engines, including Embase, Medline, Psychinfo and Cinahl. No time limits were used in the search, and the databases typically present published literature dating as far back as the 1980s. One paper which explicitly addresses metonymy and mental illness, ‘The contribution of metaphor and metonymy to delusions’ (Rhodes & Jakes 2004), was retrieved. Rhodes and Jakes (2004), drawing on Lakoff and Johnson’s (1980) theories about metaphor and metonymy, initially traced a potential metonymic motivation for a delusion expressed by a participant in their research, specifically that reference to hydrogen stood for super powers, as a part for a whole. They further stated:

> We hypothesize that many incomprehensible and seemingly chaotic one-off statements might well be a form of unexplained metonymy in that a person only mentions fragments from a domain (Rhodes & Jakes 2004, p. 7).

Littlemore (2015) reconsidered the data presented in the article by Rhodes and Jakes (2004), and speculated that other examples that the original authors assessed as metaphoric could perhaps be better explained as metonymic. Neither study makes mention of the ‘metonymic speech’ observed by earlier researchers (Cameron 1944;

Goldstein 1944). A repeated search of the databases Cinahl, Psychinfo and Medline undertaken in December 2014 uncovered no new research into metonymy and mental illness.

The database searches did not provide any links, historical or contemporary, to the literature on metonymic speech from the 1930s and 1940s (Cameron 1938; Cameron 1944; Goldstein 1944). I came across the work when I was searching for a definition of metonymy in a dictionary of linguistics and subsequently sourced the original literature.

LABELLING THEORY AND STIGMA

The powerful link between metonymy and mental illness is forged in the transfer of meaning from diagnosis as a clinical signifier to diagnosis as a marker of identity. In simple terms, this is an example of the basic referential part for whole metonymy, whereby diagnosis stands for identity. Goffman (1963, p. 51) identified how labelling others with a specific identity on the basis of certain attributes:

> … is an offshoot of something basic in society, the stereotyping or "profiling" of our normative expectations regarding conduct and character; stereotyping is classically reserved for customers, orientals and motorists, that is, persons who fall into very broad categories and who may be passing strangers to us.

Cienki (2007, p. 180), a cognitive linguist, notes how metonymy contributes to stereotyping that can lead to dangerous inferencing:

> Social stereotypes are one example of how certain salient members of a category can be used to represent the entire category (part stands for whole), with the inherent danger that inferences can be made about the entire category of people based on the characteristics associated with the one subgroup.

Goffman (1963, p. 5) had already mapped those dangers:

> In all of these various instances of stigma however, including those the Greeks had in mind, the same sociological features are found: an individual who might have been received easily in ordinary social intercourse possesses a trait that can obtrude itself upon attention and turn those of us whom he meets away from him, breaking the claim that his other attributes have on us. He possesses a stigma, an undesired differentness from what we had anticipated. We and those who do not depart negatively from the particular expectations at issue I shall call the *normals*…By definition, of course, we believe the person with a stigma is not quite human. On this assumption we exercise varieties of

> discrimination, through which we effectively, if often unthinkingly, reduce his life chances (italics in original).

Goffman (1963) does not use the term metonymy, but he does not need to. The process he describes, where one attribute's salience can overshadow all other attributes, matches the cognitive process of metonymic inference. Goffman (1963) strategically defines '*normals'* as 'We and those who do not depart negatively from the particular expectations at issue', ironically rendering the term 'normal' one that is defined contingently and negatively, that is, by what it is not, rather than what it is. He also highlights how, once a person has been marked by a selected attribute, this give others the licence to ignore other attributes the stigmatised person may possess.

Goffman (1963, p. 122) further traces elements of the operation of stigma when the line between 'normal' and other is lightly drawn:

> The general formula is apparent. The stigmatized individual is asked to act so as to imply neither that his burden is heavy nor that bearing it has made him different from us; at the same time he must keep himself at that remove from us which ensures our painlessly being able to confirm this belief about him. Put differently, he is advised to reciprocate naturally with an acceptance of himself and us, an acceptance of him that we have not quite extended to him in the first place. A *phantom acceptance* is thus allowed to provide the base for a *phantom normalcy* (italics in original).

These processes are inferential. They depend on manipulation of what is allowed to be foregrounded, and what allowed to recede into the background, that is, the operation of metonymy. Thus, an attribute typically regarded as salient, such as experience of mental illness, may temporarily be granted lesser attention, on the proviso that it may be remobilised at any time, with its full exclusionary power.

Goffman (1963, p. 122) also describes a process how a normally stigmatised person can be drawn in to questioning the operation of stigma:

> He can even be led to join with normals in suggesting to the discontented among his own that the slights they sense are imagined slights - which of course is likely at times, because at many social boundaries the markers are designed to be faint so as to allow everyone to proceed as though fully accepted, and this means that it will be realistic to be oriented to minimal signs perhaps not meant.

Again, this process depends on features of metonymy, in particular, the way that two meanings can be held in play at once. A stigmatising inference can be created, and simultaneously disavowed, possibly with genuine intent. These are dark and uncomfortable ideas. I have quoted Goffman at length, partially because of the influence his work on stigma has had over the fifty years since he published his book, but also because the link between metonymy and stigma, though implicit, is evident throughout his work.

The work of Goffman (1963) and Becker (1963) on the labelling of deviance, including psychiatric labelling, also aligns with cognitive linguistic work on how language is used strategically by groups to achieve certain interests (Gibbs 2007c). Thus behaviour that is either tolerated, or even not noted as being different, can be selected for (usually negative) attention under certain circumstances.[7]

Zola (1993), in challenging stigmatising language used about people with disability, outlined a role for the use of grammar. He posited a gradient from the use of a noun to describe a person with a disability, for example, ‘cripple’, through the use of an adjective, for example, ‘disabled person’, to the use of a full phrase, ‘person with a disability’. He argued that the first two uses still place the disability in the foreground of the reference, but the latter puts the person first. He speculated that the additional time taken to articulate the full phrase would allow speakers opportunity to reflect on the person as a whole. While the parallels with cognitive linguistic descriptions of metonymy are clear, Zola (1993) did not refer to the concurrent work (see, e.g. Lakoff 1987; Lakoff & Johnson 1980).

The recently established National Mental Health Commission has stated the importance of careful use of language in all their documents, and they use the term, ‘people with lived experience of mental health issues’ (National Mental Health Commission 2012). This incorporates the earlier work by Zola (1993) in highlighting the person or people first, and it reflects the recognition that there are people with mental health issues who have no contact with mental health services, and so cannot be identified as ‘consumers’.

A further approach to shifting stigma through changing language, with direct relevance to this study, has been the contentious call for the term ‘schizophrenia’ to be abandoned (Kingdon et al. 2007). Takahashi and colleagues (2009) report on positive changes in attitudes held by young people in Japan following the change of name of

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[7] Goffman notes one counter-example; in a private hospital, patients were referred to by bed numbers rather than their names as a sign of respect.

the disorder from ‘Mind-Split Disease’ (compare, Fusar-Poli & Politi 2008) to ‘Integration disorder’, however the study is limited as the researchers specifically compared attitudes to the terms in relation to perceptions of criminality or victimhood. In a subsequent study, Tranulis and colleagues (2013) compared attitudes toward the terms ‘schizophrenia’ and ‘salience syndrome’ held by university students, and people experiencing their first episode of psychosis. They reported that the perceived benefit of the latter term to the people experiencing psychosis rested on its relative obscurity, which enabled them to avoid societal stigma in the short term. The authors concluded that:

> The negative stereotypes, separation, power imbalance and discrimination do not wane simply by changing a label and it is probable that they infuse back into the new labels as society gets to understand their link with the new labels (Tranulis et al. 2013, p. 4).

This is consistent with the objectives of the current study, which seek to map the influence of metonymic language on the experience of people who live with mental illness, and not presume a simplistic relationship between labelling and stigma.

METONYMY AND NARRATIVE THERAPY

While there is no published literature that addresses a potential role for metonymy in therapeutic work that was located in the searches, the relevance of metonymy in Narrative Therapy can be deduced. The role of metonymy in underpinning the practice of labelling, whereby a selected attribute comes to stand for a person’s identity has been posited. The externalising conversations developed by White (2007) effectively reverse this process. In order to do this, the processes rely on a cognitive grapple with the influence of metonymy, although White did not use the term in his published work.

Cashin and colleagues (2013, p. 33), in describing narrative therapy note that:

> Much of the information we utilize is often on the back track, or disattend track, and no longer part of our conscious awareness. Schemata develop in the form of narratives that color our perception of the world. Narrative therapy is aimed at surfacing alternate ways of seeing problems and how the person is positioned in relation to the problem which in turn influences their ability to move forward in a less-distressed way.

This demonstrates further alignments between metonymy, as described in cognitive linguistics, and narrative therapy. The concept that we mobilise information in ways that are unattended fits with the notion that metonymic language is frequently not noticed. The description of the influence of narrative schemata maps to the Sapir-Whorf hypothesis that language influences how we think and experience the world (Lakoff 1987). Narrative therapy works by ‘surfacing alternate ways of seeing problems’ (Cashin et al. 2013, p. 33), which parallels the way that metonymy functions to foreground salient elements of a concept (Langacker 1993).

There are parallels with other approaches to language and therapy In White’s work that are not explicitly addressed. The respectful attention to the actual words people use recalls Peplau (1952/1988) and Meares (2005).[8] The validation of ‘experience-near language’ recalls Goldstein’s (1944) respondent who called green, ‘the color of the grass in Kentucky’. His recognition of how narrative can be remade resonates with the words of a key cognitive linguist:

> Human beings go beyond merely imagining stories that run counter to the present story. We can also make connections between different stories, or more generally, between different and conflicting mental spaces (Turner 2007, p. 378).

While not intended therapeutically, Turner highlights elements of narrative that are taken up in narrative therapy: the capacity to imagine different stories; and the power to make connections through narrative, notwithstanding the presence of conflict.

Conclusion

While it is possible to trace recurring themes about language and mental illness across different discourses, these are not reflected within any one disciplinary discourse. Cognitive linguists use identical examples to nursing theorists, but the insights each discipline draws about these examples are not incorporated into the other approach. Psycholinguists perform multiple observations on the language of people with mental illness, and speculate about the meanings of their findings, but do not ask their participants what the experience means to them. Therapists from a variety of disciplines champion the primacy of people’s own words, but are often blind to neuropsychological impairments that underpin some of this language use.

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[8] Prior to his death, Michael White discussed meeting Russell Meares, and being excited by some of the parallels between narrative and conversational therapy, and by their shared interest in the work of James and Vygotsky. The potential collaboration they reportedly planned never eventuated.

There is a gap in our knowledge, as evidenced in the published literature. This study takes as its focus the topic of metonymy as it is experienced by people with mental illness. Metonymy has been explicitly addressed within rhetoric, linguistics and psychiatry. Metonymic influences underpin labelling theory in sociology, and the resultant stigma people experience. It is also evident in identity formation processes that highlight certain personal attributes as salient, while letting others recede into the background. This study explores metonymy in its explicit and implicit forms, through the words of people who live with mental illness.

CHAPTER 4: METHOD

'You can't record auditory hallucinations, put them on a tape'
[Michael, Interview 2, line 375].

Introduction

The previous chapters addressed the concepts underpinning the study, and identified how the various literatures that were reviewed provided suggestive ways to explore the topic. The methodological approach to the study was qualitative and interpretive as the research was aimed at ascertaining what issues, if any, language posed for people with mental illness, and then exploring any identified issues in detail. There was, however, no straightforward method described in the research literature that would answer the research questions.

Data collection was through interviews with people who live with mental illness, and who had experienced psychosis. Two interviews were conducted with each participant using the Biographical Narrative Interpretive Method (Wengraf 2001) for data collection. For analysis of data, two approaches were applied. First, Template Analysis (King 2004) was employed deductively to code the language participants used within the interviews. The data thereby coded was synthesised, in order to inductively develop the overall themes that arose from the interviews.

This chapter describes the reasons for the approaches taken to data collection and analysis, including the selection and recruitment of participants, the conduct of the interviews, and the process of analysis. There was a tension implicit in the topic under study. On the one hand, I aimed to understand the meaning that people make of their experiences, an approach that must, to some degree, take people's statements at face value. On the other hand, I also aimed to analyse their words from a cognitive linguistic point of view, which posits language choices as frequently occurring unconsciously and as being influenced by internal and external factors. The research method was developed in part to manage this tension. The method included a combination of techniques from oral history, linguistic analysis and template analysis, and incorporated deductive and inductive analytic strategies.

Participant selection and recruitment

The study was designed to explore the language of people who have had psychotic illnesses, in particular, how people experienced language when they were in recovery. Many linguistic phenomena observed in acute psychosis frequently remit once treatment is initiated (Docherty 2012), and I was interested in the type of language problems that persisted and influenced people's everyday lives. Participants' views on these experiences were more likely to be accessible when they were not in an acute psychotic state. The study was designed to elicit information in more depth than simple confirmation from participants that problems exist. It was also designed to ascertain if there were discernible patterns of metonymic language use, by and about people who live with mental illness.

The first inclusion criterion for participation in the study was that the person had experienced psychosis, as the subject of the thesis was to explore their experiences. The second criterion was that they had the capacity to provide informed consent. As I was the sole researcher and conducted all of the interviews, transcribed and analysed the data, participation was restricted to people who can speak English, which is the only language I speak.

Participants were recruited through two means. Eight participants were recruited through clinical contacts within one local health district. The study was advertised to clinicians through presentations in 'in-service' sessions. Clinicians would then approach individuals who met the inclusion criteria to check if they would be interested in participating, providing them with the written 'Information for Participants' (Appendix A). The potential participant could then choose to contact me directly, or provide details for me to contact them. The study was also advertised on two websites accessed by people with interest in mental health; the New South Wales Consumer Advisory Group, and the Schizophrenia Fellowship of New South Wales with a brief explanatory text (Appendix B). Two participants contacted the researcher directly in response to these advertisements.

Ten participants were interviewed. Nine participants were also interviewed a second time. All participants were engaged with some form of mental health treatment on a voluntary basis. None of the participants were receiving involuntary treatment under mental health legislation. None of the participants were experiencing acute psychosis at the time of either interview. All participants were taking prescribed anti-psychotic medication, and several participants were also taking mood stabilising medications.

Data Collection

Interviews were chosen as the method for data collection. Interviews enable the researcher to ascertain the thoughts and opinions of particular people about a certain topic (Minichiello et al. 2004; Wengraf 2001). They are ideally suited to exploring people's views about their own experience but it is not possible to guarantee that they provide facts about that experience. For instance, if an interview participant tells of an encounter with another person, that other person may have a different, and indeed contested, view of that encounter. However, if the researcher wishes to elicit the meaning a person attaches to their experience, asking the person is a straightforward means of achieving this. Interviews enabled the collection of data in the form of participants' authentic speech for the purpose of linguistic analysis.

What constitutes acceptable language data has become a contentious issue in the discipline of cognitive linguistics. Cognitive linguists have been criticised for relying too heavily on constructed examples of speech rather than empirical data (Brdar-Szabo & Brdar 2012). Traditionally, most of the writers on metonymy have simply provided constructed examples themselves. Many of these mirror, or at least approximate, actual speech with a fair degree of authenticity, but they are constructions. One approach to address this concern is the study of 'corpus linguistics', that is, analysis is conducted on data from an existing authentic language source (Markert & Nissim 2003). In this approach, examples of context-based language are analysed, often focused on very specific types of language, including jokes and place names (Feyaerts 2000; Langacker 2009). The data are selected from pre-existing data sources, which have typically been created for the purpose of analysis of language, but not for answering a specific research question. In this study, I have conducted interviews and created a specific data set for empirical analysis.

An elicited narrative is not everyday language. Wengraf (2001) highlights the fact that, notwithstanding their preparedness to assist the researcher, research participants invariably bring feelings related to previous experiences of being interviewed to the encounter. Nonetheless, relating stories is not an atypical use of language in many domains, so, while telling a requested narrative to an interviewer may be unusual, most participants will have prior experience of relating narratives to others. Fischer-Rosenthal (2000, p. 116), an historian who participated in the development of the Biographical Narrative method used in this study, notes:

> Empirically, everyone is able to tell their life story, narrate a biography or parts of it in defined situations… Such situations range from hardly institutionalised occasional interactions between strangers (in a bar, in a train) to repeated narration in one's own social milieu (after dinner, during family celebrations), to highly formalised organisational settings (job interviews, visits to the doctor, testimony in court, political campaign speeches) (parentheses in original).

While Fischer-Rosenthal (2000) does not specifically address occasions where the elicited narrative may include discussion of mental health, people who live with mental illness have almost invariably had experience of delivering their narratives for the purpose of clinical assessment. A person may be called upon to provide a biographical narrative on numerous occasions and this demand carries particular pressures for people who experience mental illness, especially when this includes psychotic experiences. At a basic level, people cannot always recall episodes when they have been psychotic, so including these in a narrative is either not possible, or relies on reports of actions and speech from others. These can be difficult to integrate into ‘self-knowledge’ as they are reported, not recalled. During psychotic episodes, people can think and act in ways that are uncharacteristic of their behaviour at other times. It can be difficult to reconcile these experiences for oneself, let alone provide an account to others that integrates them. This underlines the choice in this study to request narratives from people in established recovery from acute psychosis.

BIOGRAPHICAL NARRATIVE INTERPRETIVE METHOD

The specific interview method was adapted from the Biographical Narrative Interpretive Method (Wengraf 2001). The study had a two-fold purpose, to elicit participants’ own views about language, and to collect data exemplifying their own use of language. The Biographical Narrative method enabled data to be collected to meet this dual purpose. The method comprised two interview sessions, the first aimed solely at eliciting narrative from the interviewee, the second allowing the researcher to directly include their theoretical concerns with the participant and further explore aspects of the initial interview that are relevant to the research topic. The approach was designed to create a body of language data relatively uninfluenced by the researcher in the first instance, while subsequently allowing for the person to express their own thoughts about the topic.

INTERVIEWS

Interviews were conducted over nearly three years, from February 2012 until October 2014. Interviews were conducted in a range of settings, including rooms within the Faculty of Health at the University of Technology, Sydney, private rooms in regional libraries, two people's workplaces and the gardens of a drop-in centre for people with mental illness. Key factors in the choice of locations were that they were convenient for participants, and not clinical settings.

INITIAL INTERVIEWS

As the name of the method implies, the first interview ideally consisted of a single question, inviting the participant to tell their narrative. The question was deliberately couched in non-pathologising language, without use of diagnostic or other medical terms. At the beginning of the interview, I asked participants a single question, 'Can you tell me your story from when you started to notice that things were different or unusual, up to whatever point of your recovery you wish to go to?' Additional questions were asked in a way that prompted the participant to deliver further narrative. More typical personal interview questions, including requests for participants' emotional or evaluative responses to events they narrate, were avoided. I took note of key points raised by the person that seemed to have particular meaning within their narrative, and toward the end of the first interview session, requested further narrative in relation to these points. Wengraf (2001, p. 128) notes:

> It is important to use their words-for-feelings - and indeed their words-for-anything - rather than use your own, which may mean something different to them.

Again, the questions in the initial interview were restricted to generating narrative; seeking clarification about details was reserved for the second interview. While the intent of these interviews was research-based, not therapeutic, the explicit focus on the person's exact words accords similar values to participants' self-expression as a number of therapeutic approaches (Meares 2005; Peplau 1952/1988; White 2007).

At the end of the first interview, I had a narrative, in the person's own words, which included the events that the participants themselves had selected as personally meaningful. One of the advantages of this method was that it allowed the interview participant a significant level of control about what they chose to discuss. I did not ask questions designed to probe or challenge the participant. This interview approach created a situation in which the participant could determine what they would address.

Conversely, this also gave a measure of responsibility to the participant to manage risks to their sense of safety. The method was therefore appropriate to the research topic, experience related to mental illness, which carried the potential to include distressing memories for participants.

In most interviews, the number of turns taken by the interviewer and the participant is controlled almost exclusively by the interviewer, as they are asking the questions. The first interview in the Biographical Narrative method reverses this power dynamic, as it is the interview participant who decides how long to speak in response to a question, and therefore when the interviewer may take their next turn.

SECOND INTERVIEWS

The data from the first interview were provisionally analysed, and a second interview was typically conducted a month later. The second interview created the opportunity for me to directly question the participants about issues related to the research topic. My preliminary analysis of the data from the first interview was discussed with the participant. At least three types of questions were asked in the second interview. I presented my interpretation of the data from the first interview, and ascertained the participant's views on this interpretation. A second type of question elicited clarification of specific details, and information relating to the participant's own views about the experiences they related. Thirdly, I asked questions related to the research that were not specifically raised in the first interview. Thus, at the end of the second interview, in addition to the initial narrative, I had information about the person's evaluation of their experience and opinions on the research topic.

The second interviews were conducted between three weeks and six months after the first interviews for each participant. The variation in these periods relates to external factors that influenced the availability of the interviewer and the participants, not to delays in performing provisional analysis of the data from the first interviews.

For each of the second interviews, there were a number of set questions that were asked of every participant:

> Is there anything you would like to change, add or delete from the previous interview?
>
> Have you had the experience of not being able to follow the speech of other people?

> Have you had the experience of other people not being able to follow your own speech?
>
> Have you had any experiences where the language used by mental health workers helped or hindered you?
>
> If I asked you, ‘Would you like another glass?’ what would I mean?

Apart from the first question, which was always asked at the beginning of the second interview, the questions were not necessarily asked in this specific order, but interspersed throughout the second interview in order to maintain flow. I also asked the majority of participants to reflect on two words, ‘insight’ and ‘recovery’, that have specific and contested meanings within mental health discourses.

The fifth question was introduced as a ‘quick quiz’: ‘If I asked you, “Would you like another glass?” what would I mean?’ This question was aimed at directly testing what pragmatic inferences people would draw from a typical metonymic phrase. The question was designed to ascertain participants’ capacity to comprehend metonymy in an ‘everyday’ context. It is a prototypical referential metonymy, where the container stands for the contents. It is an example of metonymy that potentially could be interpreted literally, that is, the speaker could simply be offering the person a second glass. However, in most contexts, it is the non-literal meaning of the contents, for example, water or wine, that is present as the salient feature.

For each participant, there was also a series of questions more directly pertaining to the first interviews. In particular, examples of their use of language were outlined, and they were asked if they were aware of this use, and if so, whether this involved deliberate choice. For instance, one participant consistently used gender neutral terms when talking about significant people in her life; another used only clinical terms to describe his experience of psychosis; and a third frequently completed my sentences before I did, using the words I would have chosen. Each of these phenomena were explored with participants in the second interviews.

Data Management

In total, fifteen hours of interview data were recorded, which resulted in just under 400 pages of transcript. Interviews were recorded using a digital audio recording device. I transcribed all of the interviews verbatim. This was undertaken in order to develop strong familiarity with the material, including how the transcript reflected the tone and timing of the recordings.

I used a transcription style where passages of text are separated by commas to indicate slight pauses. This renders the flow of speech more accurately than strict punctuation. I have not noted small vocalised pauses like ‘um’ and ‘ah’ as in the passage from recording to text these can inadvertently present the speaker as less articulate than they are. I have retained all fillers, for example, ‘you know’, ‘like’, and ‘and that’, as they do convey speaker’s style. For the same reason, when a person’s speech includes grammatical inconsistencies, for example, ‘If I was’, I have not corrected these. I have used words rather than phonetic approximations, for example, ‘want to’ rather than ‘wanna’, as these prove distracting to readers.

The transcripts were imported into QSR International’s NVIVO 10 (2012), a software program used for managing qualitative data. Data were initially analysed using the Template Analysis method (King 2004).

Data Analysis

The first research question in the current study was, ‘How does the use of metonymic language influence the experience of people who live with mental illness?’ In order to answer this question, one arm of the analytic process was designed to consider the data thematically. A number of themes were identified *a priori*, as I knew I wanted to explore the issues of identity, stigma, and people’s experience of language, particularly their experiences of language encountered from mental health workers. These themes have been identified in the literature (see, e.g.Barnes & Berke 1971; Brown & Kandirikirira 2007; Goffman 1968; Lysaker, Roe & Yanos 2006; Ross & Goldner 2009; Shefer et al. 2014) and I was interested to know if they were salient in participants’ lived experience. This entailed deductive analysis of the data to identify if these themes were present. Hammersley (2008, p. 69) notes, ‘it is impossible to begin research without prior assumptions of some kind’. However, the study was intended to be both interpretive and explorative, and an integral part of this was to analyse the data inductively as well. This entailed observing for recurrent themes arising in the narratives, and also noting ideas or experiences that weren’t necessarily recurrent, but cast the processes in a different light.

The second arm of the analytic process was designed to investigate the language in which participants conveyed their narratives, in order to answer the second research question: ‘How do metonymic patterns influence the speech production and speech comprehension of people who live with mental illness?’ This entailed examining the language for cognitive linguistic, clinical and narrative features. The analytic method thus combined several approaches that were to run concurrently, prior to being synthesised. Template analysis was selected as the method that enabled me to maintain organisation of the disparate streams of analysis, but also make them available for synthesis.

TEMPLATE ANALYSIS

Data were deductively analysed using a series of templates. This method has been described by King (2004, p. 256) who states that:

> The term ‘template analysis’ does not describe a single clearly delineated method; it refers rather to a varied but related group of techniques for thematically organizing and analysing textual data.

Typically, thematic analysis involves a process of coding ‘chunks’ of data that fit certain themes that have been identified in advance as relevant to the research question(s) (Wengraf 2001). In template analysis, these themes are literally organised in a template, so the researcher is referring to the pre-existing codes as they analyse (King 2004). The data are then analysed, coding for these themes, but also being alert to themes arising from the data. The template was revised to reflect themes that emerge from the data, and also to remove initial codes that were not reflected in the data. A final template was then set and all the data re-analysed. Coding the data using the final template does not represent the final step in analysing the data – the templates exist primarily to help organise the data and support analysis.

King (2004, p. 258) flagged the potential for parallel coding, ‘whereby the same segment is classified within two (or more) different codes at the same level’. My use of template analysis introduced an adaptation from the beginning. Template analysis typically codes data for themes only, arranging these in hierarchies in order to synthesise the analysis. In addition to thematic analysis, I conducted linguistic analysis of the data, and while this intersected with the thematic analysis, it was not incorporated into a hierarchical structure for synthesis, but remained distinct.

TEMPLATES

I analysed the data using four templates; one thematic, one identifying language practices described within cognitive linguistics, one using terms from the Thought, Language and Communication Scale (Andreasen 1979a), and one using Wengraf’s ‘textsort’ categories (2001). Parallel coding occurred within templates, for instance, a segment was coded as evincing the themes of ‘Experience of language’ and ‘Experience of treatment’. Parallel coding also occurred across templates, for instance a segment was coded thematically as ‘identity’, and also as an instance of ‘metonymy’ from the cognitive linguistic template.

An initial *a priori* set of codes were established within each template, capturing the key elements of the research questions. I knew that I would be looking for examples of metonymy, and other aspects of language identified in cognitive linguistics. I also knew that I would be considering certain thematic aspects, including identity, the experience of symptoms, and experiences related to language, especially in encounters with health workers.

These initial codes were trialled using some of the data, then further refined to reflect information arising from the data. A number of codes were added, for example, I had not anticipated the extent of use of idiomatic language, and so established a code to track this. Codes were also deleted, after preliminary analysis revealed they were not substantially present in the data. A final set of templates was constructed, and all data, including that which had been provisionally analysed, were coded to this set of templates.

TEMPLATE 1: THEMES

The data were analysed thematically. The template of codes for themes underwent the most change of the four templates following preliminary analysis of the data. This is consistent with exploratory qualitative data analysis, where themes frequently emerge from analysis of data. I had known I wanted to investigate several themes from the outset of the study. These included the theme of identity and how people formed their sense of self. I deliberately did not link this to explicit references to the influence of mental health diagnosis on identity formation, as I wished to elicit the broadest ideas people had about identity, and understand what elements they themselves selected in this process. Indeed, I did not even wish to presume that identity formation was a salient idea for participants. I knew that I would be looking for examples of stigma. I also knew I would be investigating people’s own words about their experiences of language, and their experiences of treatment, though here again, I did not want to explicitly link the two processes, at least in the first interview.

A number of earlier thematic topics included resilience, the experience of psychosis diminishing, and coping mechanisms. These had been suggested both by my clinical experience, and from the literature (Brown & Kandirikirira 2007; Deveson 2003; Slade 2009). However, in response to analysis of the data, the concept of recovery better captured these. Another topic that was added was ‘insight’ as this came up repeatedly in the narratives. The final set of themes that were coded is set out in Table 4.1.

Table 4.1 Themes

Term	Definition
Experience of symptoms	Experience of symptoms of mental health issues, including positive and negative experiences
Experience of treatment	Experience of treatment by health professionals, including mental health professionals
Experience with language	Notable experiences of language. Includes differences in speech production and comprehension, as well as experiences of language used about them
Identity	Participants’ expressed thoughts about identity
Insight	Both participants’ expressed thoughts about the term, as well as reported experiences of developing insight
Recovery	Both participants’ expressed thoughts about the term, and reported experiences of recovery
Stigma	Experiences of overt or perceived discrimination related to mental illness or other attributes. Includes self-stigma

TEMPLATE 2: COGNITIVE LINGUISTIC TERMS

The research questions that guide the study focus on metonymy as it is defined in cognitive linguistics. Metonymy is not the only process attended to within this field of study and it frequently occurs in combination with other figures of speech. A number of salient features were identified. These are listed and defined in Table 4.2. These were mostly set before the data were analysed, as they were key concepts guiding the study. Idiom, irony and understatement were added after the preliminary analysis of the data, as they recurred frequently. As metaphor has been addressed widely in therapeutic and cognitive linguistic literatures, I decided only to include it when it was particularly notable.

Table 4.2 Cognitive linguistic terms

Term	Definition
Blend	Blending is in principle a simple operation, but in practice gives rise to myriad possibilities. It operates on two Input mental spaces to yield a third space, the blend. The blend inherits partial structure from the input spaces and has emergent structure of its own (Fauconnier 1997, p. 149)
Ellipsis	The omission from speech or writing of a word or words that are superfluous or able to be understood from contextual clues (*Oxford Dictionaries* 2015)
Idiom	An idiom is a linguistic form consisting of two or more morphemes in a construction whose overall meaning is not derivable by compositional means from the meanings of the component morphemes in that construction (Talmy 2007, p. 276)
Irony	A form of speech in which one meaning is stated, and a different, usually antithetical, meaning is intended (Preminger, Warnke & Hardison 1986, p. 109)
Metaphor	A form of conceptual projection involving mappings or correspondences holding between distinct conceptual domains (Evans 2007, p. 136)
Metonymy – referential	Metonymy in which a source term is used to indirectly refer to a target object or an entity, and the terms are linked by conceptual contiguity.
Metonymy – predicational	Metonymy in which the substitution of source for target addresses the properties of an object, rather than the object itself
Metonymy – illocutionary	Metonymy in which a speech act stands for an indirect request
Simile	A form of metaphor where the link between concepts is specified as ‘like a…’ or ‘as a…’
Understatement	The presentation of something as being smaller or less good or important than it really is (*Oxford Dictionaries* 2015)

Blends, Idioms and Understatement all frequently depend on metonymy to function, either as motivating factor, or in combination with metaphor. This confirmed Gibbs’ (2007a, p. 697) assertion that, ‘In fact, it is nearly impossible to speak of many human events without employing idiomatic phrases that communicate non-literal meaning’. The coding of cognitive linguistic terms posed specific challenges. The disagreement among linguists about the borders between different terms was noted in the chapter on Metonymy, and recently restated by Littlemore (2015) in her monograph about the topic. Moreover, as Barthes (1994, p. 86) notes:

> Yet we still lack (but perhaps such a thing is impossible to produce) a purely operational classification of the principal figures: dictionaries of rhetoric, indeed,

> permit us to discover what a *chleuasmus* is, or an *epanalepsis*, or a *paralepsis,* to proceed from the often quite hermetic name to the example; but no book allows us to make the converse trajectory, to proceed from the sentence (found in a text) to the name of a figure; if I read: *so much trembling over so much shadow*, what book will tell me this is a *hypallage*, if I do not already know this? We lack an inductive instrument.

In the absence of such an inductive instrument, the transcripts were considered multiple times, and examples of key figures subjected to repeated analysis prior to inclusion in the results.

TEMPLATE 3: ANDREASEN'S THOUGHT, LANGUAGE AND COMMUNICATION SCALE

In tracking other notable aspects of language use, the Thought, Communication and Language Scale first developed by Andreasen (1979a) was used as another template to enable reliable differentiation of the data. While the scale has explicit diagnostic and prognostic intent that is not part of this particular study, it is used here as it contains operationalised definitions of language patterns observed in the speech of people who live with mental illness. These are set out in Table 4.3 below. As many of the terms had arisen in the first pass through the data, it was simple to adopt the scale, and there is an advantage in discussing the findings in using a widely cited scale. The term 'scale' is slightly misleading. Andreasen, after providing operationalised definitions for the aspects of language, also developed a numeric scale, with items variously ranged from 0 to 4 or 5, in terms of their frequency of use. In the event, in all published articles by the author and colleagues (Andreasen 1979a, 1979b; Andreasen & Grove 1986; Docherty 2012), any item that rated a 1 or above, that is, occurred at least once in the data, was counted for the purposes of analysis, thus rendering the numeric scale redundant.

Table 4.3 Andreasen's TLC Scale

Term[9]	**Definition**
Blocking	Interruption of a train of speech before a thought or idea has been completed.
Circumstantiality	A pattern of speech that is very indirect and delayed in reaching its goal idea. In the process of explaining something, the speaker brings in many tedious details.
Clanging	A pattern of speech in which sounds rather than meaningful relationships appear to govern word choice, so that the intelligibility of the speech is impaired.
Derailment	A pattern of spontaneous speech in which the ideas slip off the track onto another one that is clearly but obliquely related, or onto one that is completely unrelated.
Distractible speech	During the course of a discussion or interview, the patient repeatedly stops talking in the middle of a sentence or idea and changes the subject in response to a nearby stimulus.
Echolalia	A pattern of speech in which the patient echoes words or phrases of the interviewer.
Illogicality	A pattern of speech in which conclusions are reached that do not follow logically.
Incoherence	A pattern of speech that is essentially incomprehensible at times.
Loss of goal	Failure to follow a chain of thought through to its natural conclusion.
Neologisms	New word formations. A neologism is defined here as a completely new word or phrase whose derivation cannot be understood.
Perseveration	Persistent repetition of words, ideas or subjects so that, once a patient begins a particular subject or uses a particular word, he continually returns to it in the process of speaking.
Poverty of content of speech	Although replies are long enough so that speech is adequate in amount, it conveys little information.
Poverty of speech	Restriction in the *amount* of spontaneous speech, so that replies to questions tend to be brief, concrete and unelaborated.
Pressure of speech	An increase in the amount of spontaneous speech as compared with what is considered ordinary or socially customary.
Self-reference	A disorder in which the patient repeatedly refers the subject under discussion back to himself when someone else is talking.
Stilted speech	Speech that has an excessively stilted or formal quality.
Tangentiality	Replying to a question in an oblique, tangential, or even irrelevant manner.
Word approximations (Paraphasia, metonyms)	Old words that are used in a new and unconventional way, or new words that are developed by conventional rules of word formation.

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[9] All of the terms and definitions in Template 3 are from Andreasen (1979a, pp. 1318-21)

TEMPLATE 4: NARRATIVE MODES: WENGRAF'S 'TEXTSORT' CATEGORIES

A final template was used to code the transcripts into the 'textsort' categories outlined in the Biographical Narrative method, as described by Wengraf (2001). These categories are set out in Table 4.4. They are intended as a means of distinguishing different narrative practices that participants used within an overall narrative. However, there are not strict boundaries between the categories; they are suggestive rather than fixed. The advantage of the textsort categories is that they are more flexible than standard narrative divisions, in which the parts of narrative structure are determined by their temporal sequence in the overall narrative, for example, abstract/ orientation/ complicating action/ evaluation/ resolution/ coda (Labov & Waletzky 1967/1997).

Table 4.4 Wengraf's 'textsort' categories

Term[10]	**Definition**
Description	The assertion that certain entities have certain properties, but in a timeless and non-historical way
Argument	The development of argument and theorizing and position-taking, usually from a present-time perspective
Report	A sequence of events, experiences and actions is recounted, but in a relatively experience-thin fashion
Narrative	The telling of a story by which event Y followed event X, and event Z followed event Y, either for causal reasons or just 'because they did'. The story is not told in a very 'thin' way…but rather in 'rich detail'
Evaluation	The 'moral of the story' stated explicitly as such.

Even with this relative flexibility, the interviews were not able to be coded strictly to the model outlined by Wengraf (2001), as most participants moved between narrating styles more frequently than was consistent with the model. Nonetheless, these shifts between textsort categories did occasionally correlate with shifts in other linguistic features, for example, higher density of figurative language was noted when participants were using a 'report' mode in the textsort categories, than when they were using an expanded 'narrative' mode.

SYNTHESIS OF TEMPLATE ANALYSES

Subsequent analysis consisted of examining intersections between coded items, to identify patterns and trends. Some of these were flagged in the research questions, for example, metonymic use of diagnosis (from the cognitive linguistic template), and

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[10] Terms and definitions are adapted from Wengraf (2001, pp. 243-244)

identity (from the themes template). Patterns that characterised the speech of individual participants were also observed. Synthesis of the data also persisted through the interpretation of results, as themes and linguistic features emerged in the process of setting out results in a communicable fashion.

Ethical considerations

The study was initially reviewed by the Human Research Ethics Committee (HREC) of Sydney Local Health District and approval granted (Reference X11-0031 & HREC/11/RPAH/41). This approval was subsequently ratified by the University of Technology HREC (Reference 2011-109R).

The research was guided by The *National Statement on Ethical Conduct in Human Research* (2007/2015) which states that, ‘People with a cognitive impairment, an intellectual disability, or a mental illness are entitled to participate in research, and to do so for altruistic reasons’ (National Health and Medical Research Council, Australian Research Council & Australian Vice-Chancellor's Committee 2007/2015, p. 58). A key aspect of the current research was to give voice to the experience of people who live with mental illness in relation to an issue where they have generally been treated as research subjects, rather than participants, and their language performance assessed ‘objectively’ by researchers. At the same time, and in consideration of, ‘participants’ distinctive vulnerability’ (National Health and Medical Research Council, Australian Research Council & Australian Vice-Chancellor's Committee 2007/2015, p. 59), care was taken to minimise the risks to participants.

INFORMED AND VOLUNTARY CONSENT

Capacity to give informed consent was established through direct discussion about the study with candidates, checking that they understood the benefits and risks prior to signing a written consent form (Appendix C).

Participation in the study was voluntary. I did not directly recruit the participants, in order to reduce the potential for coercion, or perceived coercion for people to participate. I had worked in the local health district from which participants were recruited, and had previously met four of the participants; two of these people had no clinical contact with me, and the other two had participated in group activities that I coordinated, but had never received individual treatment from me. Participants were not offered compensation for their interviews. In several cases I offered to pay for people’s transport to the interview locations, but none of the participants accepted this offer.

RISK AND BENEFIT

The discussions I held with all participants prior to requesting their informed consent to participate in the study included consideration of the risks and benefits that would potentially arise from their participation. The primary risk was that narrating their stories could include recalling traumatic events, and that this would lead to distress. All participants reported awareness of this risk. The measure of control held by the interviewee in the Biographical Narrative method partially mitigated this risk, and beyond the request for their story, I did not ask questions that probed potentially distressing topics. Participants were also aware that there would be no direct benefit to them through participation in the study. Several participants explicitly voiced their understanding that their participation could potentially lead to the generation of knowledge about the experience of language of people who live with mental illness.

I was aware of the privilege of being granted participants' narratives of their experience for the purpose of my research. While maintaining participants' confidentiality, I have also attempted to respond to this privilege by treating their stories with respect. The process of selecting excerpts from people's narratives is the researcher's responsibility, and there is the possibility that participants may consider my selections as not presenting the most salient examples of their experience, or my interpretations as not truly representative of their thought. Several participants expressed recognition that this may occur, and stated altruistic intent as motivating them to participate in research that may contribute to improvements that would benefit others.

PARTICIPANT DISTRESS

The request to narrate previous experience can bring up unexpected emotional responses in anyone. For people with experience of mental health issues, there is often a history of trauma, either as a result of symptoms themselves, through service system related events, or through negative experiences, including being stigmatised by other people, including family members, employers or strangers. As a mental health nurse, I had over fifteen years' experience of responding to people in distress. Throughout the interviews, I remained attuned to people's responses.

With three participants I paused the interviews to suggest to people that they did not need to continue with the interview, as they were expressing distress as they recalled past experiences. One participant reported it was traumatic to recall an incident that occurred during his first hospital admission. Another participant reported that she generally avoided thinking back on certain experiences, as she felt such thinking hampered her moving forward. A third participant evinced significant distress when recounting certain past events, but respectfully declined the interviewer's offer to stop the interview, stating that the emotions were congruent to what she was discussing, and she was able to manage her distress.

In each instance, participants opted to continue, though two participants shifted from the topics they had been discussing. I did not attempt to counsel any of the participants, but offered to arrange counselling if they felt they may benefit from it. No participant took up this option. At the beginning of the second interview, I checked with each participant if there was anything they wished to add, alter or delete from the previous interview, and none did.

One participant expressed reluctance to participate in the second interview, reporting that the initial interview experience had brought issues to his mind that were distressing. In discussion, it came to light that he had planned to participate in the second interview despite this reluctance, as he stated he did not wish the information he had provided in the first interview to be lost to the study. When he was reassured that information from the first interview could be included in the study without his participation in a second interview, he expressed relief and opted not to return for the second interview.

CONFIDENTIALITY

Care has been taken in presenting information provided by participants in the chapters on Results and Discussion. All data were coded with a participant number, converted to a pseudonym for the purposes of reporting. Pseudonyms have been used for the participants, to protect the identity but not interfere with the readability of the results. Information that may be used to identify participants or people to whom they refer has been de-identified. Participants may be able to identify elements of their own narrative, or direct quotations they have made, but other readers will not be able to link information from the study to particular individuals. Care has been taken when a narrative includes sensitive information about a third person; this has typically been excluded from the reported data, in order to avoid the potential for inadvertent identification of a person. All references to proper names that may be used to identify people or organisations were removed from the transcripts. Written transcripts of the interviews were kept in a locked cabinet. Electronic data, including audio recordings were stored in password protected files on a personal laptop, and on a password protected external hard drive.

Reflexivity

I worked as a mental health nurse for over fifteen years, with the majority of these spent in direct clinical contact with people with a range of mental health problems. Over the course of the study I changed my employment position more than once, moving from direct clinical contact with people who live with mental illness, to consulting with them for the purpose of policy development.

I had been thinking about some of the ideas that underpin the present study for several years prior to beginning. I had studied mental health nursing and counselling, undertaken workshops in Narrative Therapy with Michael White, and attempted to integrate these ideas into my clinical practice. I therefore came to the study with certain ideas already, as well as a set of values about working with people who live with mental illness within the public mental health system.

Within my experience as a mental health nurse, I had conducted many interviews with people with a range of presenting problems. These interviews largely fell into two types; assessments and therapeutic encounters. In the first type, assessments, I was asking questions in order to formulate clinical impressions, and develop plans with the person about what kind of intervention might help them. In the second type of interview, therapeutic encounters, I would ask questions in order to evaluate their current mental state and response to previous interventions, and formulate ongoing plans with people about how they may achieve and maintain improvements in their mental health, again, in many contexts and with people experiencing a range of difficulties. These questions would frequently incorporate my professional responses to the information I was hearing.

Conducting interviews as a researcher with people who experienced mental illness required that I relinquish both of these long-practised approaches. It was important that I not introduce the ‘fact-finding’ intent of the assessment interview, as this would distort my capacity to gather participants’ narratives in their own words. It could also have generated unease in participants, reminding of them of clinical encounters, and undermining their sense of contributing to research. Nor was I interviewing in order to practice therapy with participants. This would have represented a blurring of my professional boundaries.

This dual need, to practise new interviewing skills while keeping others in check, was challenging at times. I had to learn how to convey empathy to participants as a researcher, which is a key part of conducting a successful qualitative interview, while not couching this in terms of my professional knowledge. This was particularly challenging when participants directly requested my clinical opinion on matters they were discussing; when this occurred, I would respond with general comments, and refer them back to their treating teams for detailed discussion. One way in which I managed these issues was to discuss the challenges they presented with my principal supervisor.

I also kept a journal throughout the interviews, where I noted my observations of elements that contributed to building and maintaining rapport with participants, which questions stalled, and which created flow and cohesion. I referred to these notes when I was preparing for second interviews with individual participants, and to guide my overall research interviewing style.

The study presented me with other challenges beyond adopting a researcher stance rather than a clinical one. A risk in qualitative research is that the researcher only finds what they set out to find (Hammersley 2008). This risk is compounded when the researcher has a very specific familiarity with the topic under consideration.

Some of the steps that I took to address this issue involved the establishment of the study, while some of them are related to the analysis. In the first instance, I made a decision to conduct interviews with people with whom I had not had direct clinical contact, the majority of whom I had not met prior to conducting the study. This reduced the possibility that people would have already heard my particular thoughts about language, or been influenced by my ideas directly through clinical encounters. Collecting data in the form of extended narratives also created a space wherein information I could not anticipate would be provided by participants. Following the Biographical Narrative method, I had minimal influence on what people chose to discuss in the initial interviews. Thus, a significant proportion of the data on which I based my analysis was outside my control, and therefore less likely to be subject to bias through the introduction of topics or questions.

The second set of steps related to the analytic method. There are the themes I was particularly interested in when I began the study, including the role played by metonymy in the formation of identity, and the production of stigma. I was transparent about looking for these, and they were part of the deductive template analysis aspect of the study. During analysis of the data, themes I had not anticipated recurred, and I recorded these and reviewed all the data several times to check on them. This forms the inductive aspect of the study, and the two approaches are synthesised in the final report.

Beyond the themes, which were set, either deductively or inductively, by the researcher, I also conducted linguistic analysis of the data, using terms described in the cognitive linguistic literature, and also terms from earlier research into language and psychosis. These analyses strengthened the study, creating data that can be reviewed independently of the thematic analysis, but can also be used to support the perceptions of experience reported by participants.

Conclusion

In conducting the study, I was seeking to accomplish a number of things. I wanted to explore the views of people who live with mental illness about their experience of language. I also wanted to analyse their language, to ascertain if there were distinctive patterns that contributed to the way they experienced language. There was no documented method that would allow me to explore the research questions set out in the Introduction. In consultation with my principal supervisor, I developed a hybrid method, which combined a data collection process that created two types of response to the research questions with an analytic process that allowed for a number of different approaches to the data to be maintained and synthesised. The results of the study are detailed in the next chapter.

CHAPTER 5: RESULTS

This chapter sets out the results of analysis of the information provided by participants in the interviews. The first section of the chapter summarises information about the participants, including the mental health diagnoses they have and the types of mental health treatment they have received. The second section describes the interviews themselves.

The third section of the chapter presents the key themes identified in the data analysis of the interviews. These are described thematically, in order to reflect the experiences participants report across varied domains. The specific themes that are addressed are: identity, stigma, the experience of symptoms, the experience of treatment, and insight and recovery. Information from the analysis of the other templates, including cognitive linguistic terms and narrative styles, is incorporated into the thematic results. This is consistent with the way in which these elements function, underpinning the thematic expressions.

The final section of the chapter presents analysis of the data about participants' experience of language. This includes examples of typical and atypical language use demonstrated by participants, as well as their expressed views on their experience of language. The sections help to organise the data, but they are not rigid. Where there is an overlap between topics, this is identified.

The practice of pragmatic inferencing was evident throughout the data, with participants describing both situations where they were making inferences about other people's meanings (speech comprehension), or where they perceived inferences being made about them (speech production). These events occurred not just when attention was specifically drawn to language use, but across other domains, including the formation and reassessment of identity, the experience of being subject to stigma, and engagements with mental health workers. Metonymic language contributed to this pragmatic inferencing. Where this occurred, it is described.

Participants

Ten participants were interviewed in the study. Table 5.1 summarises demographic data about the participants, who have been given pseudonyms.

Table 5.1 Participant characteristics

Identifier	Age	Completed years of education	Diagnosis	Years since initial contact with MH services	Current vocational status
Michael	32	15	Schizophrenia	13	Working part-time/ studying
Ethan	58	16	Schizophrenia	40	Working full-time
Tanya	27	10	Schizophrenia	10	Not working
Oliver	27	13	Schizoaffective disorder	2	Unknown
Nathan	22	16	Depression with psychotic features	2	Working part-time/ studying
Yves	47	14	Schizophrenia	30	Not working
Matthew	49	13	Schizoaffective disorder	32	Not working
Ian	43	13	Schizophrenia/ Schizoaffective disorder /Bipolar disorder*	20	Working part-time
Ellen	42	16	Bipolar disorder/ Post-traumatic stress	13	Not working
Shirley	40	18	Bipolar disorder/ schizoaffective disorder	16	Working part-time/ studying

* Ian’s diagnosis was under review at the time of the interviews.

Three of the participants were female, seven male. The participants ranged in age from 22 to 55. All participants spoke English. Two participants spoke another language at home to older family members, though both were born in Australia, and had spoken English and their parent’s first language from childhood. Two other participants grew up in environments that were culturally diverse from the dominant Anglo-Celtic Australian heritage, including one person originally from the Torres Strait Islands.

Nine of the ten participants had completed high school. One participant left school at 15. Six participants had engaged in university education, with three of these completing undergraduate degrees and one completing more than one degree. Another participant had completed studies within Technical and Further Education (TAFE).

One participant was working full-time. Four participants were working part-time, with three of these combining part-time work with part-time study. Four participants were neither working nor studying currently. One participant’s occupation was not stated.

FORMAL MENTAL HEALTH DIAGNOSES

Past experience of psychosis was an inclusion criterion for participation in the study, and all participants had formal diagnoses that incorporated psychosis. Four participants had a formal diagnosis of schizophrenia, two were diagnosed with schizoaffective disorder, two had diagnoses of bipolar disorder and one had a diagnosis of severe depression with psychotic features. One person’s diagnosis was under review at the time of the interviews. Notwithstanding these formal diagnoses, several participants reported discussions with their treating teams in relation to the applicability of differential diagnoses, and these are reported in further detail below.

TREATMENT

All participants were currently engaged with voluntary mental health treatment at the time of the interviews. All participants were currently taking psychotropic medications; some were taking antipsychotics alone, while others were taking antipsychotics in combination with anti-depressants or mood-stabilising agents. Seven participants were also engaged in some form of counselling with one or more mental health workers. These included their treating psychiatrists, but also mental health nurses, psychologists, social workers, and support workers.

Nine of the participants reported they had been subject to involuntary mental health treatment under mental health legislation at some time in the past. The number of years since participants first had contact with mental health services ranged from two to 40, with an average length of 17 years. These figures do not strictly correlate with years in treatment, as several participants have had intervening periods since first contact without being on any treatment.

All participants had received treatment in the public mental health system. Four participants had been treated exclusively in the public mental health system, while six had been treated in both the public and private systems. Three participants were currently treated exclusively in the private sector, while seven maintained engagement with public mental health services.

Interviews

There was a marked range in the duration of the interviews, and the number of turns taken by the participants. These are summarised in Table 5.2.

Table 5.2 Interview data

Identifier	**Interview 1 Duration (minutes)**	**Turns taken**	**Interview 2 Duration (minutes)**	**Turns taken**	**Interview 1 Initial answer (lines)**	**Longest free passage (lines)**
Michael	31	15	43	58	104	104
Ethan	26	8	39	24	91	91
Tanya	24	34	30	46	4	17
Oliver	12	19	N/A	N/A	N/A*	24
Nathan	35	18	26	35	175	175
Yves	53	40	43	79	57	57
Matthew	34	177	27	122	2	5
Ian	54	141	61	120	15	22
Ellen	92	26	73	45	55	463
Shirley	90	15	101	51	328	328

* Due to a recording error, some minutes from Oliver’s first interview were lost.

There is no distinct pattern in the differential durations between first and second interviews for each participant, with five of the latter interviews lasting longer, and five being shorter. The average first interview lasted 44 minutes, and the average second interview lasted 43 minutes and 45 seconds.

Turns were contained as pairs, that is, 15 turns indicates that the interviewer and participant each spoke 15 times. Duration of spontaneous speech was measured by the number of lines in the transcript as this most accurately reflects the amount of content of speech. The alternate measure of duration in time measured in minutes is prone to variation in rate of speech, and so does not capture the level of content in each passage of speech.

One marked variation across participants was the number of turns taken by the interviewer and the participant. One interview [Ethan, Interview 1], consisted of just 8 turns each for the interviewer and participant, but lasted 26 minutes and generated 227 lines of transcript, of which only 12 lines were spoken by the interviewer. Similarly, another interview [Shirley, Interview 1] consisted of 15 turns over 90 minutes, with the interviewer generating 28 lines of transcript and the participant 856. At the other end of the spectrum, another interview, [Matthew, Interview 1] lasted 34 minutes, but consisted of 177 turns, and generated 474 lines of transcript, with many of these lines consisting of just a few words.

There was distinct variation in response to the requested narrative in the initial interviews. Two speakers, Nathan and Shirley, were able to speak at length (175 and 328 lines respectively) in response to the initial question. In contrast, two other speakers, Tanya and Matthew, responded with two- and four-line answers respectively. The length of initial responses did not correlate with the length of responses throughout each interview. For instance, Ellen's initial response comprised 55 lines, but later in the interview she spoke interrupted for approximately 40 minutes (463 lines of transcript), which was the longest spontaneous passage of speech in any of the interviews. Matthew's responses remained brief throughout, with no individual passage in the first interview exceeding four lines.

The second interviews were semi-structured, with a schedule of questions. For eight of the ten participants, this resulted in interviews that consisted of significantly more turns than the first interviews. Two participants' second interviews comprised fewer turns than their first (Mathew and Ian), however in both cases, the first interviews comprised many more turns than taken by the other participants.

Themes

The data were analysed thematically, with a focus on the role played by language across different aspects of participants' experience. These themes were: identity; stigma; experience of symptoms; experience of treatment; insight; and recovery.

IDENTITY

All participants reported that they had thought about their identity, and the relation of their experience of mental illness to their identity. None of the participants reported this thinking to be simple or straightforward. Participants reported that the experiences of psychosis altered their sense of reality. And they also reported that factors that accompanied the psychosis further contributed to this shift. For all of the participants, the onset of illness disrupted their anticipated life path. This affected every aspect of their lives, including relationships with friends, family and lovers, their educational and vocational ambitions, their financial capacity and their social status. Each of these aspects can stand as salient attributes in the formation of identity. So, in addition to having to incorporate the experience of mental illness into their sense of self, participants also had to make adjustments across many of the other factors that may have previously contributed to their identity. For some participants, relinquishing these other factors was as difficult as incorporating mental illness into their identity.

Participants spoke about how their sense of identity was influenced by the highlighting of certain attributes. The experience of mental illness figured as a key attribute that frequently altered people's sense of identity. In contrast to many other factors that typically shape identity, mental illness was reported as not being voluntarily selected. Shirley described how being given a diagnosis of mental illness is equated to having your future determined:

> *'Identity always comes up, because it is such an affront to your self, to your sense of self, to be given one of these words and told that's your, you know, and especially with schizophrenia, that's your destiny, and I've had doctors, and this, this wasn't helpful to me, but, and I found it quite insulting, but a doctor did say to my mum at the time, "Oh, she's got bipolar, you're lucky she doesn't have schizophrenia"'* [Shirley, Interview 2, lines 539-544].

Shirley made explicit the fact that messages that affect the impact of a diagnosis of mental illness on a person's identity are directly sent by mental health workers. She reported her own experience of this type of message as negative. For Shirley, it was through the specific naming power of language, '*to be given one of these words'* that this process occurred.

Ian also spoke of the dramatic shift in his identity following diagnosis with a mental illness:

> *'Like I was a straight-A student up until then, 14 years of age, and after that I became a zombie basically'* [Ian, Interview 1, lines 8-10].

The term '*straight-A student*' is an example of chained metonymy – first, it is the rating of performance documented in a report card that stands for the quality of student, then it is that performance as a student that stands for the self. Zombie is a popular metaphor, the walking dead that populate screens both large and small, here invoked to describe the experience of identity living with a mental illness.

Ian also described how a psychotic experience affected him particularly because of a distinct attribute that formed his identity prior to becoming ill:

> '*I did hear one voice only, ever in my, the whole experience of being in hospital, and that [said] I was going to hell. I'm a Christian guy so to hear that voice scared the life out of me, for the next ten years affected me'* [Ian, Interview 1, lines 30-33].

In the previous example, he articulated the shift in his identity using global terms. In this example, he reports the experience of psychosis as directly related to his identity, with the power of the voice stemming from its exploitation of his belief system. This recalls the '*affront to yourself*' that Shirley described, though in this instance it is the actual experience of psychosis rather than its diagnosis that leads to the effect. Ian commented on the enduring emotional effect of the voice he heard, which persisted long after his recognition that no external voice was involved, and that a plausible explanation for the experience related to the internalised guilt he felt over his use of an illicit substance prior to his first psychotic episode. In other words, the voice he heard enacted a conceptual transfer giving meaning to his subsequent experience of psychosis as a deserved punishment.

Ian voiced the strongest description of the influence of a diagnosis of mental illness on his identity and its subsequent impact. He reported he had been diagnosed with schizophrenia, and had multiple experiences of deterioration in his mental state, many of them resulting in involuntary admission to hospital. He reported that these episodes frequently occurred after he had ceased taking anti-psychotic medication, without alerting his treating team. In the last few months, he had received a second psychiatric opinion, and his diagnosis was provisionally revised to bipolar disorder, with a differential diagnosis of schizoaffective disorder. He reported he was subsequently adhering to the same anti-psychotic medication as previously prescribed, but now with the addition of a mood stabilising agent:

> *'Whereas before I was just totally disinterested in my condition, 'cause I didn't want schizophrenia, I didn't believe I had schizophrenia, the stigma that comes with it, I was, you know, ashamed of for 20 years, so, but now, believing that I have the right diagnosis, I'm happy to take medication for that'* [Ian, Interview 1, lines 549-552].

As he reported it, his readiness to take the prescribed treatment rested not in his experience of mental health or ill health, nor in the effects of the medication, but in the name given to the condition for which he was prepared to accept treatment. This demonstrates the conceptual power that resides in the metonymic shift, with the change of name given to his condition governing his willingness to assume control of his experience.

Ellen repeatedly used expressions that suggested a causative relationship between her identity and her experience: '*because I'm who I am'* [Ellen, Interview 1, line 29], *'thankfully I am me'* [line 149], '*cause I remembered who I was'* [line 151], '*a lot of things have happened to me as a result of me being who I am'* [line 269], '*I refused to, 'cause that's not who I am*' [line 440]. Ellen's identity stands for her values, even as the specific values invoked are left underspecified. The repeated phrases are ostensibly tautological, but rely on pragmatic inferencing for the selection of which unspoken attribute is salient, be that courage, forbearance or resilience.

Other participants described different strategies for managing the shift in identity caused by mental illness. Nathan played with the romanticised idea of returning to his premorbid self, weaving through some of the more colourful metonymic transfers of meaning from substance use to identity:

> *'It just didn't feel right, I didn't feel like my old self, even though my old self was a bit of a layabout, bit of a dope fiend, well not a dope fiend, a bong rat'* [Nathan Interview 1, lines 174-175].

'Layabout' evinces metonymy whereby the (in)action comes to stand for the person, while the attributes attached to substance use, both demonic and murine, are almost comically negative. These metonymic references also suggest that these terms have particular understandings within a microculture of language use, with certain concepts being salient for participants in that group. For those outside, it may not be possible to infer the distinctions between 'dope fiend' and 'bong rat', though for this speaker, the shift in nuance was clear.

Nathan voiced the positive aspect of linking identity to a specific attribute:

> *'There were some ups, yeah, my first gig with a show called XXXX, cause I'm a roadie, my first gig at XXXX, that was a bit of an up, watching them onstage, as a roadie, yeah, just anytime that I was working was an up'* [Nathan, Interview 1, lines 205-207].

Here it was his work role that gave him a sense of value, the very act of watching the band transformed by his experience of doing so from a specific and recognized identity position: '*as a roadie'*.

For Ethan, who first developed schizophrenia in the 1970s, his reported strategy was not to return to a prior identity, but to adopt an alternate identity by highlighting other available attributes:

> '*I was trying to mask my mental illness by being seen as a dropout or a hippy or a drunk or a drug addict because there was nothing worse than, you know, being seen as a lunatic, you know, because you had no credibility, you're not taken seriously, in those days people didn't know how to treat people with a mental illness'* [Ethan, Interview 1, lines 53-57].

His masking strategy involved adopting a series of other identities, all of which were preferable to being perceived as mentally ill within an unwritten but nonetheless powerful hierarchy of stigma. Questioned further about this in the second interview, he laughed about his success:

> *'I think it was a very unsuccessful strategy because people thought I was crazy as well as drunk'* [Ethan, Interview 2, lines 54-55].

Each of these identities, dropout, hippy, drunk, drug addict, lunatic, relies on a metonymic transfer of an attribute to speak the whole of his identity. Notably, the selected attributes of the less stigmatized identities, lack of vocational functioning, physical self-presentation, and substance use, all carry a potential to be voluntarily relinquished. '*Lunatic*' however, carries the mark of permanence, and involuntary attribution.

Ethan goes on to contextualise the alternative options that were available to him at the time:

> *'[In] the 70's, there was a kind of, round, you know, in the dying days of the Push, you know, there was a kind of rebellion and actual affirmation of oppressed groups, I didn't see it very much reflected in mental health stuff then, but certainly with the women's movement, the gay movement, student power, anti-Vietnam war protests, the hippy movement, which is somewhat discredited now, but it was very strong then, you know, there was multiple avenues for me to try and disguise my mental illness as alienation or disaffection with the system'* [Ethan, Interview 2, Lines 60-67].

Implicit in his description is the fact that a key element of the majority of the other movements he names involved assuming identity positions related to membership of a specific community.

Michael's approach to distancing himself from an identity formed in relation to mental illness was different again:

> *'I mean it's alright if like, 10% of the time I go, "Oh well, yeah, that's me as a schizophrenic", but I don't want, you know, 70% of me to be that schizophrenic'* [Michael, Interview 2, lines 188-190].

He expanded on this, explaining that, for him, it was the whole process of an attribute standing for his identity that was questioned, not simply the choice of valued attributes over non-valued ones. He reported the possibility of enjoying aspects of himself, while retaining separation from globalising suppositions based on these enjoyments:

> *'I would go to church occasionally but I wouldn't be comfortable labelling myself a Christian, yeah, I don't really see much of a point in labelling myself, I know who I am no matter what my activity is, yeah, like, I enjoy bushwalking but I don't call myself a bushwalker'* [Michael, Interview 2, lines 196-199].

In both instances, rejecting identity imposed or presumed on these other selected attributes supported him when it came to maintaining identity separate from the experience of mental illness, no matter how influential or traumatic that may have been.

Participants' responses to the influence of the experience of mental illness on their identities included elements of choice within the process, even though they did not choose to have mental illness. Participants also described experiences that arose subsequent to their diagnoses that they did not choose, specifically, the experience of stigma.

STIGMA

All participants reported experiencing stigma related to their mental illness. This stigma occurred from strangers, from friends and acquaintances, from family members, and from mental health workers. Participants also reported experiencing stigma related to attributes other than mental illness, including race or ethnicity, gender, employment status and faith. A number of participants also reported self-stigma, that is, negative thoughts about themselves related to having a mental illness.

Ethan identified the role of mass media, and the representations of people who live with mental illness it reinforces, as contributing to the experience of stigma:

> *'I also see that the media has a certain view of mental illness that's different from mine, even today there's, there was a story about a mentally ill man who*

> *might be somewhere in the US that killed five people, so big headlines 'Mentally ill' so even though it's probably true, he was mentally ill, it, just having it there actually feeds that view of us you know as unstable, violent, it's very difficult'* [Ethan, Interview 2, lines 273-278].

This is echoed by Yves:

> *'You hear them say, you know, "Oh, some psych patient's going to grab a gun and kill people"'* [Yves, Interview 2, lines 171-172].

Yves' experience of mental illness spanned decades, and he observed that stigma was becoming more noticeable in recent times. Whereas in his early encounters with strangers and police when he was first psychotic he was treated with kindness and some humour, he now reported increasingly frequent use of derogatory language from strangers and acquaintances, and more social withdrawal by others once his diagnosis was known:

> *'I think it, like, people, the way people talk about psychiatric patients and stuff now, I hear more, I hear a lot of like, nonsense all the time, and I never used to hear that, yeah, you know they call you loony or something, or you know, or a psycho or something, and sort of like, they don't have an education sort of, on schizophrenia or bipolar or manic depression or anything'* [Yves, Interview 2, lines 88-94].

Yves articulated a direct link between people using stigmatising language and people having a lack of education about mental illness.

Ian used an idiomatic expression to describe the experience of stigma:

> *'People have always got it in the back of their mind, that something's wrong, or not quite right'* [Ian, Interview 2, lines 116-118].

This idiom blends metaphor and metonymy; the mind is metaphorically described as a container, and a thought, '*that something's wrong',* metonymically located spatially within that container, specifically '*in the back*', that is, not in plain view. Ian, like Yves, drew a link between the lack of understanding of mental illness by the broader community and its correlation with stigma. As he explained it, this ignorance was less about how a person may or may not be expected to act in public, but about the actual experience of mental illness:

> *'The torment you go through, it's the torment that you go through, that you need relief from, and anguish, the pain that's on the inside, I mean you can never explain to someone, if someone sees a big gouge out of your arm at least they can see the pain, they can sympathise with what pain you might be going through, but mental illness, you can't see anything, so no-one can sort of have any sort of sympathy or empathy for you, really if they doesn't, if they don't know, if they're not a professional in the field, the general public have no idea about mental illness and are quite scared of it'* [Ian, Interview 1, lines 608-615].

He suggested that the lack of understanding of mental illness in the community is associated with fear of it, and of the people who experience it. For Ian, this ignorance is based on the invisibility, and the ineffability, of the suffering experienced by people with mental illness.

Ian also pondered how much of his own sense of stigma in relation to the diagnosis of schizophrenia is related to the word itself:

> *'I don't like the word schizo for some reason, so schizo, even schizoaffective, I don't like the word schizo, I don't know why that is, so there is a stigma even in the word for me, because the whole idea of schizo is double-minded and shattered, and all these sort of images, sort of something is, yeah, broken and not whole, you know what I mean? And, just thinking about it now, schizo to me sounds like a word that is shattered, like it's a shattered word, does that make sense? If you're talking about your mind, I don't like to think of your mind as being shattered, and, you know what I'm saying? So I think I have a stigma towards the word more than the illness'* [Ian, Interview 2, lines 391-399].

This passage demonstrates a process of thinking aloud; Ian articulated that he was thinking through these ideas as he spoke. His analysis of his own responses shifted back and forth between examining the etymology of the term '*schizo'*, and an exploration of his reactions to the sound of the term, that lend it almost onomatopoeic strength. He went on to ask a metalinguistic question:

> *'You know, why don't they call it a nice name? [laughing] "Ian's a brainiac" and then people would go, "Oh, OK"' [laughing]* [Ian, Interview 2, lines 435-436].

While this suggestion was offered light-heartedly, it is consistent with the particular intensity of his responses to the sound of the prefix '*schizo*'. On this last idea about the influence of naming, Shirley stated an opinion which stands in direct contrast with Ian's:

> *'I mean, I personally think stigma follows around whatever language you choose for the experience'* [Shirley, Interview 2, lines 27-28].

She prefaced this statement with an observation that, despite the term 'manic depression' being replaced by 'bipolar disorder' thirty years ago in clinical use, she still encountered the term regularly from members of the community, frequently accompanied by stigmatising attitudes.

Though Shirley's statement contradicted Ian's in relation to the influence of language on stigma, her observations about the effect of the invisibility of mental illness echoed his, and raised further issues:

> *'I would classify what I experience as pretty invisible disability and hard to articulate and describe and ask for accommodations around'* [Shirley, Interview 2, lines 183-185].

Like Ian, Shirley described mental illness, and the disability associated with it, as both difficult to see, and difficult to articulate. As a result, she had experienced difficulty in accessing services and study support to which she was entitled, due to failure on the part of agency representatives to recognise her mental illness.

Shirley also talked about how many of the images on posters and other resources designed to combat stigma against people with mental illness ironically contribute to it by portraying normalised versions of what it is to have mental illness. She observed that people are typically presented as being in groups, well dressed, clean and smiling. The real experiences of many people with mental illness, including social isolation, mental distress, and medication-induced weight gain, are effectively erased from these representations. Shirley reported that people who experience these things do not recognise themselves in these images, but instead see repetition of the normative expectations that they frequently struggle against.

Shirley offered further observations on the consequences of the invisibility of mental illness, based on her experience:

> *'I've learnt lots of common assumptions people make, and they're usually wrong, the main one being, I'm not the sort of person that gets depressed, I'm a different type of person, I don't, I'm not that type of person, so people must have this fixed idea of who gets depression and who doesn't, and I don't fit the mould apparently, I think 'cause I'm chatty and I can still be chatty, within reason, I mean, there's a certain level of depression where I can't function at all,*

> *but I can be, as long as I'm kind of able to get out of bed and put clothes on and get myself out the door, I can usually talk, but I can be in pretty bad shape and still talk, and I think people associate being able to talk, or hold a conversation, or pretend to be OK, as passing'* [Shirley, Interview 1, lines 470-481].

She described situations in which she found herself, a person with serious mental illness, being assessed by others as not meeting the '*fixed idea'* of what kind of person has mental illness. There are advantages and disadvantages to this. On the one hand, it meant she was not subject to the stigma reserved for persons identified with mental illness, and this had pragmatic consequences, including her capacity to retain her job. On the other hand, her own experience was rendered invisible, and she was exposed to the expression of prejudice, even though it was not directly applied to her.

Tanya was characteristically pragmatic about how to minimise the potential for stigma:

> *'I don't go out in public and, you know, put a pole up and raise the flag' (laughing)* [Tanya, Interview 1, lines 128-129].

Her statement underlined the relative invisibility of her mental illness, and some measure of capacity to control visibility should she wish to.

EXPERIENCE OF SYMPTOMS

Participants spoke of the specific experiences of psychosis they had. These included delusions, hallucinations and thought disorder. At times participants used these clinical terms directly, but they also used the term 'voices' for auditory hallucinations. The experience of psychosis was frequently reported as scary or disturbing, but not universally so; several participants reported some enjoyment of their experiences.

Michael used simile to convey his experience:

> *'One time I came home after class in my room, and all my classmates' voices were in my head as if, as if I was like at a function, with everyone talking around me, [circling hands around back of head], and that was really scary and frustrating because my own head was creating all this noise, it's like going to see a concert where there's noise musicians just making a whole racket in my head*' [Michael, Interview 1, lines 38-43].

In both cases, the terms he used evoke social situations where he would expect to hear noise, a function and a concert. However, it was the coupling of this sense of other people deliberately making noise with the recognition that it was his '*own head* *creating all this noise'*, that gave the experience its emotional effects of fear and frustration. Shirley and Ian described how difficult it was to articulate the experience of mental illness. Michael, in his efforts to convey what it felt like to experience psychosis, used figurative language.

Michael further grappled with how to accommodate the experience of auditory hallucinations, identifying that the evidence of mental illness is inaudible for others, as well as invisible:

> *'I'm thinking of auditory hallucinations, I know people say, "Oh yeah, they're real", but they might be, I don't know, I don't see that they are real, I mean it's OK for them to say that they're real, just like a thought is real, but nobody else hears the thought. You can't record auditory hallucinations, put them on a tape, that's why I like tangible things because I can remember tangible things better'* [Michael, Interview 2, lines 372-376].

Michael identified that being able to hear something does not guarantee that it is real, and pointed out that all thought, not just auditory hallucinations, cannot be heard by others. He expressed his own preference for another sense, touch, '*because I can remember tangible things better.'* The last point introduces not just another mode of perception, but also one of cognition, that is, memory, suggesting that it is not just the event experienced in the moment, but also the way the event is recalled that contributes to its impact.

Yves echoed Michael's sense of recognition that voices aren't real, but described how nonetheless the experience interfered with his functional capacity:

> *'I've never thought the voices have been real or something, yeah like the delusions, but it does sort of interfere with your everyday life, showering even sometimes, and going out and, you know, making sure you've got clean clothes, not lying in bed, cause the voices would be so bad sometimes I'd just have to lie in bed, just take it easy and that'* [Yves, Interview 1, lines 111-115].

Yves reported that his experience of symptoms was sometimes so bad that he could not go out. This is another example of how aspects of mental illness can be invisible to the broader public as, literally, the person remains unseen.

Yves described how his symptoms interfered with his functional capacity. Ethan reported the disturbing experience of thought blocking; rather than a symptom getting in the way of his thinking, his thinking itself was blocked:

> *'When I went to university it was really developed in a big way where I had the whole range of different things, one of the most unsettling was a kind of thought blocking where I felt my brain was switching off and I couldn't concentrate this would mean I could look at, start reading a book and you know stare at the one paragraph for a very long time and go into a kind of dream world, looking back it was a bit like being asleep and having a dream or hallucination rather than being in reality'* [Ethan, Interview 1, lines 16-21].

For Ethan, as for Michael, the experience and the memory of the experience were linked. Again, like Michael, Ethan used simile to capture what it felt like, '*a bit like being asleep and having a dream*'. Ethan also described how his thinking about how he might recover was altered:

> *'I had this insane theory that if I, you know, descended into madness and sort of somehow came back in reverse the same way, I'd become well again, that I could do it myself'* [Ethan, Interview 2, lines 265-267].

Ethan's description of his theory is articulated in spatial terms, in particular, his use of the phrase '*descended into madness*'. Ethan demonstrated use of a form of predicational metonymy widespread in the community, transferring a property from a human to a non-human object, mentioning his, '*insane theory'*. This usage also evinces the prevalence of terms denoting mental illness being used loosely, even by people with increased awareness of the influence of such language.

Ethan drew a direct link between some of his experience in the real world, and his delusional thoughts. In particular, he reported a sense of powerlessness after he became ill, that had material effects on his life in terms of the disruption to the vocational trajectory he had previously been on. This powerlessness periodically resurfaced in the delusional belief that he was a political prisoner, which in turn offered an explanation for the shift in fortunes he had undergone.

Shirley also reported experiencing this type of delusion. In two episodes of acute psychosis which occurred fifteen years apart, she was listed as a missing person, as she left where she was staying without informing anyone. In both cases, she had the belief that someone intended to do harm to people close to her, specifically because of her actions. In the second instance, her belief was that drug companies were planning to abduct her relatives to punish her for her advocacy work around side effects. It is possible to trace a metonymic pathway for these delusional beliefs.

Shirley pointed out that not all of the symptoms she experienced were unpleasant, including this wry account of the influence of environment on the experience of psychosis:

> *'London's quite a good place to sort of flip out, because everything actually is sort of connected, 'cause there's all, you know, every building's designed by Christopher Wren, or there's some, there's always coincidences everywhere, you know, or you're standing on someone's grave when you don't realise it on the footpath, and you know, so it's actually pretty trippy'* [Shirley, Interview 1, lines 210-214].

Her description captured the way in which meaning can be attached to place, and how this meaning can escape attention altogether or alternately be inferred correctly. Her inference is that this kind of meaning is always available in certain contexts, and that a shift in how one is mentally experiencing the environment can increase access to inferring these meanings. This may give rise to another reason to '*descend into madness'* as Ethan phrased it. Shirley reported on the next phase of her symptoms:

> *'I always liked to go and moon around Greenwich and, you know, hang out round the Observatory Hill, and so I'd do a bit of that, and I remember coming back by ferry from Greenwich one day and it felt like everything that was happening in, the whole city was happening because of me, like it was a great big procession and it was all caused, in and around and because of me, which is quite extraordinary'* [Shirley, Interview 1, lines 265-269].

Her own assessment of the experience was that it was '*extraordinary',* that is, the inference that everything in the city was occurring because of her was not disturbing or frightening. Her description, '*moon around Greenwich'* deftly blended a verbal phrase metaphorically derived from cosmology with the location of an astronomic observatory.

In counterpoint to the problems identified with the invisible aspects of mental illness, Shirley pointed out a very specific type of visibility she had in this phase of her illness:

> *'When I'm like that I can be quite compelling and quite persuasive and quite charming and quite mischievous, and quite energising to other people'* [Shirley, Interview 1, lines 248-250].

The effect of her presentation at this time was to disguise the severity of her illness, which deflected the attention of those trying to help her, deferred clinical intervention and contributed to a dangerous deterioration in her mental state. This too was a matter of pragmatic inferencing, with the attributes that were deemed salient by those around her being read as positive aspects of her personality, leading them to incorrectly underestimate how unwell she was.

Ian also reported ambivalence about his experience of symptoms:

> *'I'd hate to stay like this, 'cause I can't sleep and I can't settle, I can't turn off, but there's part of it, the productive side of it, I definitely like, because normally by nature I'm a bit lethargic'* [Ian, Interview 1, lines 318-320].

Ian's reported experience of hypomania echoes Nathan's evaluation of himself prior to the experience of psychosis, both recognising patterns of low energy and motivation before becoming unwell. Ian also related an experience of acute psychosis that he did not find disturbing:

> *'But the funniest story I could tell you about being manic and what I thought I was going to be, become, I'll tell you this, I thought I was going to become a horse in the Melbourne Cup, like, I told this story in the foyer of the XXXX clinic the other day, and like, what would happen was, I'd be sitting watching the television, and then all of a sudden, just before the race started, I'd become the horse, the favourite, like, say it's Kingston Town, I'd become the favourite of the race, but I'd know that I was Ian, as a horse, as the favourite, if that makes sense, and so I'd just run, knowing I was going to win, and then I'd win the Melbourne Cup, this guy that had just been in there for depression, balling his eyes out 'cause he was sad, turns to me and he goes, "Would you be a gelding?", and so he starts joking with me and in the end he was laughing his head off, and that's why I want to make my story known, because some of the stories I have are quite funny, there's stories I have that are sad, like the arm and that, trying to cut off the hand, but there's some stories I can tell you about the manic side that are brilliant and make people laugh, and that's why I like to tell my story, because it can help people know that you can go from this to this, and then back to normal, anyway, it's a good story, and it's just like, oh yeah, I'd say, "No I'm not a gelding, the boys would be there, you know, they'd be there", and I'd pin the ears back and take off, and I'd, I'd win the Melbourne Cup, and then I would, five minutes after the race I'd become Ian again, back on the couch in his lounge room, having to go and have a shower because I'd just won the Melbourne Cup as a horse [laughing]. That's a good thought, isn't it?'* [Ian, Interview 1, lines 445-466].

Ian narrated his experience of novel symptoms. His stated evaluation was that it was a good story, not a negative one. Moreover, he reported the retelling of the story as performing a valuable function; practically through raising the spirits of a depressed person he met in a clinic waiting room, and potentially through informing a wider audience of how bipolar disorder can be experienced.

Ian's narrative demonstrated a number of linguistic and narrative features. Within the overarching narrative of his experience of being a winning horse in the Melbourne Cup, he embedded a secondary narrative about another time when he told this story. The way in which he was able to swap back and forth between the narratives, placing the joking response to his listener some distance away from the reported question, and interspersing the narratives with commentary on the power of stories, came across as skilled storytelling, rather than disorganised thinking conveyed via circumstantiality.

His retort to the question '*Would you be a gelding?'* played with use of a whole for part metonymy, '*the boys*' standing for the body part excised from a gelding. He conveyed his winning speed through an idiom, '*pin the ears back'*, which again features a bodily metonymy, with '*ears back'* standing for the overall streamlined shape necessary to win. The intensity with which his experience of the winning the race as a horse was embodied was strikingly evinced by his need to shower afterwards. It is, of course, possible that he was sweating with excitement on a balmy Spring afternoon watching the race, and that this ordinary bodily experience lead to his delusion rather than *vice versa,* but this is not the meaning that he inferred from the experience.

Nathan reported a transient but powerful belief that he was going to die when he was in hospital, because he had been placed in a room near older people. He also reported that he believed every passing voice he heard from the corridor was talking about him. This latter experience could be described clinically as an illusion, as the meaning he inferred was prompted by a real, and not imagined, stimulus.

Not all participants reported interest in the meanings inherent within their psychotic experiences. Tanya dismissed the idea that the content of her auditory hallucinations may have held meaning: '*Oh, it was just all this racist crap'* [IV 1 line 176]. She reported the content of the hallucinations was not dissimilar to language she experienced in reality, and she dismissed both as not being important to her.

EXPERIENCE OF TREATMENT

Participants described a range of experiences of treatment, both positive and negative.

POSITIVE EXPERIENCES

Participants spoke of engagement with mental health workers as key elements in their experience. Matthew was broad in his praise:

> *'I must admit, I have very fond, fond memories of all the nurses and doctors at both XXXX hospital and XXXX clinic, and I have nothing but the greatest admiration for them, they really helped me'* [Matthew, Interview 2, lines 118-120].

This praise was repeated by Ellen, whose evaluation introduced a further element, the idea of being treated as a human being, in a relationship with other human beings:

> *'I've been blessed with having nurses who actually have treated me like a human being, and it's just a natural kindness and respect, irrespective that we happen to be in a psych ward and they're in the role of the nurse'* [Ellen, Interview 2, lines 30-33].

Ellen identified both '*the role of the nurse'* and the environment of the '*psych ward*' as potentially inhibiting the '*natural'* occurrence of this interaction between human beings by highlighting that the interactions took place '*irrespective'* of these factors. Ethan echoed the importance of being treated '*as a human being'*:

> *'That thing about key people being there and treating me as a human being, not a circus freak or something like that is really important to me'* [Ethan, Interview 1, lines 211-213].

He also used a metaphor '*not a circus freak'*, invoking the spectre of a stigmatised category of persons from a previous generation. Again, like Ellen, Ethan highlighted the possibility that he may not have been treated as a human being when engaging with mental health workers, even while reporting that he was treated well.

Ethan also talked specifically about the careful use of language by his treating psychiatrist:

> *'He actually was very good and gentle in explaining the fact that because of this, he thought that schizophrenia was a label, and that it, sort of, broadly speaking it fitted me, but he wasn't going to say "You're schizophrenic", you*

> *know, he was just going to actually work with that'* [Ethan, Interview 2, lines 171-174].

This therapeutic encounter occurred in the 1970s. Ethan reported his psychiatrist stating that the diagnosis could function as a label, and explicitly making clear that he would not use this as a global term for him, but rather use the term while keeping it separate from Ethan as a person. Ethan was the only participant who had not been treated as an involuntary patient under mental health legislation, and he attributed this outcome to a combination of factors, including his longstanding collaboration with mental health workers.

Medication

While many of the positive experiences of treatment reported by participants were in relation to their engagements with mental health workers, seven participants also explicitly stated that taking anti-psychotic or mood-stabilising medication significantly contributed to their mental health. Most of these participants reported that getting the right medication, often after long periods of ineffective pharmacological treatment, was a key step in their recovery.

For Matthew, who reported he had recently remained out of a psychiatric inpatient unit for twelve years, after multiple involuntary admissions between the ages of 16 and 37, medication was one of three critical factors in his recovery:

> *'What changed was, a more inner understanding of myself, my religious faith, and the very good and the very important help of the medication'* [Matthew, Interview 1, lines 50-51].

Yves reported waiting a long time before finding the right medication:

> *'I probably heard voices for about 20 years before I found a really good medication that took them away'* [Yves, Interview 1, lines 30-31].

He had also experienced many involuntary admissions over the previous 20 years, but at the time of interview he had not been in hospital for three years. The benefit Yves enjoyed from this change went beyond avoiding coercive treatment, as the severe effect of the voices on his capacity to function was noted previously. At the time of the interviews, Yves had also successfully made the move from living in an institutionalised boarding house, to living in independent housing.

Michael also traced a broader change in his circumstances as a result of finding the right medication:

> *'It's my autobiography and thankfully clozapine has changed that story a bit, and yeah, like I'm working in mental health now, that's a big change from being just a consumer'* [Michael, Interview 2, lines 218-220].

He drew a direct link between the effects of the medication on his vocational capacity, and on the narrative of his life.

Shirley also noted the impact of a particular medication on her functional and vocational capacity:

> *'It wasn't really much of a life and for me what ended up being quite effective was one of the epilepsy drugs which is lamotrigine, which as far as I know is still not on the PBS [Pharmaceutical Benefits Scheme], and that's something that really needs looking at, because to be quite frank, that has been the difference between me struggling to type numbers in a data entry screen, and being able to work professionally as a trainer and travel and do honours degrees and, you know, so I think I, you know, I think there's public policy things that need to be considered when we look at having the full suite of options open'* [Shirley, Interview 1, lines 547-554].

Shirley drew on her own experience of achieving significant benefits from a specific medication to state an advocacy position in relation to ensuring access to the most effective treatments for everyone affected by mental illness.

NEGATIVE EXPERIENCES

All ten participants reported negative experiences in relation to their mental health treatment. These reports were offered spontaneously, as part of their responses to the request to narrate their own experiences. The events they reported as negative occurred across the time span of participants' experiences, from the 1970s until the time of the interviews, 2014.

Ellen reported that in her experience, the attitudes that mental health workers demonstrated through their language were problematic. Her observation was that they seemed to link mental illness with lack of intelligence:

> *'The language that's used is very much, in my experience, is you're spoken to as if you don't have a mind, as if, as if there's no intelligence and you don't understand*' [Ellen, Interview 2, lines 21-23].

For Ellen, this was not restricted to language, *'With the language goes the tone and the attitude*.' [Ellen, Interview 2, line 40], and incorporates non-verbal communication including gestures, '*It's very difficult to communicate with someone when they're looking at their watch.'* [Ellen, Interview 2, lines 208-209]. This last observation depends on a non-verbal metonymic inference, that a worker looking at their watch is signalling impatience by drawing attention to the time. Later, Ellen expanded on her perception of a further aspect of workers attitudes, that a person under an involuntary treatment order lacks capacity to make decisions, and therefore must have actions taken on their behalf:

> *'The mental health professionals in the hospital, yep, it would, they, they just had, you just were treated differently, from the moment you give signed and, you know, you're scheduled, that's it, you have no, you have, you can't think for yourself, so we're here to think for you, that's pretty much what happens'* [Ellen, Interview 2, lines 341-345].

Ellen told her story in her own style, which was characterised by these kinds of assertions about other people's thoughts. In narrative terms this is an example of argument, as she adopted a position from the present perspective on past events. Her viewpoint was expressed, but not followed by concrete examples that would illustrate her statements. Ellen's speech also frequently demonstrated the kind of shifts evident in this example, with sentences and even parts of sentences left unfinished before she moved on to the next point.

Ian reported his experience as a mental health inpatient in the 1990s in graphic terms. He stated that while he was dealing with overwhelming guilt, depression and psychosis, he had absconded from the ward, and tried to cut his wrists. Inspired by his belief in Jesus, he then changed his mind and returned himself to the ward:

> *'I went back there, got put in a room by myself for half an hour before the doctor arrived, wasn't offered a drink, I was absolutely gasping for water or something, doctor came in, stitched me up, there was no-one, no-one available to counsel me, ask me where I'd been for five hours, or you know, no-one asked me any questions, they just left me and took me down to, after I had the stitches, took me down to ward XX and threw me in there like I was being thrown into gaol,*

> *and then at night, the nursing staff were asleep, so all the other patients would come and steal your bedding while you were trying to sleep, it was just atrocious, and you're in absolute agony with your arm, and all this is going on*' [Ian, Interview 1, lines 278-286].

Ian reported that his visible physical injury was treated, while other, less visible, aspects of his physical well-being, including thirst and pain, were not dealt with by the staff. Moreover, he reported that his mental state, which had led to his self-injury, was not addressed.

Ian was also critical of the inferences he perceived his treating team made about his response to electro-convulsive therapy (ECT):

> *'When I started ECT, it takes away your memory, so I forgot what I was worried about for a while [laughing], so it looked like I was getting better, but they weren't actually dealing with the problem'* [Ian, Interview 1, lines 183-185].

For Ian, it was clear that the inference that the treatment was effective was incorrect, and he reported he was discharged still suffering from the depression with which he initially presented, but with the additional problem of acquired memory loss from ECT. Ian expressed some pessimism about his experiences with inpatient services, and the inferences that he saw in effect, summarised by his stated opinion, *'From a health worker point of view, you'll always be mentally ill.'* [Ian, Interview 2, line 124]

Nathan was also critical of the treatment he received after a suicide attempt:

> *'I was put on suicide watch all night, or what I thought was suicide watch, it was just a security guard sitting outside the door the whole night'* [Nathan, Interview 1, lines 192-193].

He identified a gap between the purpose of the protective intervention as stated in the language, and its implementation in practice. Nathan also reported how he used language to influence his treatment:

> *'I remember going in to see a doctor and we talked about what was the best plan for me to keep well, and I just spouted all this bullshit just to get out of there, because I just was scared of getting admitted'* [Nathan, Interview 1, lines 78-80].

In his telling, he implied that the doctor colluded with him in ostensibly respecting his version of insight, in order to expedite his discharge from the hospital.

Other participants reported their experiences of gaps between service policy and service delivery. Yves reported times when he had been refused anti-cholinergic treatment to reverse the side-effects of anti-psychotic medication, even when clinicians acknowledged that he was clearly exhibiting signs of dyskinesia. His stated view was pessimistic:

> *'You don't have any say in it, it's sort of their system'* [Yves, Interview 1, lines 234-235].

Yves identified that the '*system*' was enacted by individual clinicians and in his view, at times it was operating to meet their needs rather than those of the people receiving care, even when this meant foregrounding a history of anti-cholinergic abuse over present clinical evidence in a treatment decision.

Oliver was critical of his treatment as an involuntary patient of public mental health services, and he also invokes the system as an important element. The following lengthy excerpt from his narrative demonstrates the language practices he used to express his thoughts:

> *'It's sort of like, what we could afford and stuff, and sort of, how it was because I think maybe if I went to like, XXXX [private clinic] or something, and was just under supervision for a while and had counselling and stuff, but because I go to XXXX [public hospital] and everything's happening so fast, and they want to straight away diagnose and medicate and, sort of, get you out of there, yeah I think, yeah, my parents didn't know what to do, so they just listened to, "OK, that's what's meant to happen", so yeah. I did feel anger for quite a while but, like, not angry at any one particular person, because I think every psychologist, psychiatrist I spoke to and that, they seemed to have my best interests at heart, they didn't seem like evil people or whatever, but yeah, just maybe the system a bit but, yeah it always comes down to, to the facilities, if it's, if there's money I guess, if there's enough money for everyone to get the proper treatment. [pause]. What happened, when I went there, that got me angry, because I spoke to the doctor when I arrived and I told them about this, I think I can, you know, you know, and she said, "OK, we'll put you in under supervision", so I went in and I said, "OK, I'll go in under supervision", and next morning I woke up and the nurse came and tried to give me this medication and I said, "Oh, they told me I'm just under supervision", I said, "Who authorised that?" and they said, "Oh a doctor this morning", and I said, "Oh, but I haven't seen a doctor*

> *this morning", and I said, "So how can someone authorise something without even meeting me?", and they said, "Oh, they read your file", and I said, "I'm not a piece of paper", I said, "I'd like to talk to the doctor please", and I spoke to the doctor and they said, "OK, we'll have you under supervision", and I didn't really, for two weeks I was OK in there, like I was never aggressive to anyone or whatever, maybe my thoughts, yeah I thought I was OK, but yeah, yeah [pause] I think with communication, [it] happened with the nurses a few times and that, they sometimes, they don't know, but they just make something up a bit, like, and they should be just honest, like, even if it's hard to hear and the person might react in a bad way, they should still get the truth before, like anything else, you know, because if you start to not trust the people who are there to help you, then you sort of, yeah [long final pause]'* [Oliver, Interview 1, lines 47-77].

In the first section of the passage [lines 47-58], he stated a general critique of the public mental health system. The language he used here was relatively vague; the passage includes fillers, ellipses, and metonymies. The fillers '*and stuff*' and '*sort of*' are each repeated more than once. He reported his parents' confused reaction to the speed with which events were occurring using ellipsis, '*they just listened to'* [line 52] and projected resignation '*OK, that's what's meant to happen'* [lines 52-53]. He stated his anger at his treatment, but deliberately deflected this from individual health workers, instead metonymically highlighting *'the system'* [line 56], and *'the facilities'* [line 57] before suggesting an argument based in health and economic policy, '*if there's enough money for everyone to get the proper treatment'* [lines 57-58]. This passage is categorised in narrative terms as a report.

After a pause, Oliver resumed speaking, but he now narrated a specific episode that made him angry, where an agreement that had been made with him to remain in hospital under observation was changed without any consultation [lines 58-69]. He described in close detail a series of verbal exchanges between himself and various mental health inpatient staff over one night and one morning. His language changed markedly in this passage. He repeatedly used direct speech, with the phrases '*I said'* and '*they said'* followed by words reported as direct quotations, ostensibly reproducing these interactions verbatim. He again made strategic use of metonymic language. In response to the reason he was reportedly given for the lack of consultation '*"Oh, they read your file"* [lines 66-67], he made explicit that the consideration of a document about him had been made to stand for direct communication with him. In order to assert his right to have a decision regarding his treatment appropriately discussed with him, he deliberately extended the metonymy '*file*' used by staff further, and stated, '*I'm not a piece of paper"* [line 67], creating a metonymic chain to underline his point. Oliver reported that he was subsequently seen by the doctor, and the initial treatment agreement upheld.

Following this narrative of a discrete episode in his care, Oliver shifted once more to a different narrative mode, in which he evaluated his experience of communication with mental health workers, particularly nurses [lines 71-77]. His language again became more general, with repeated reference to a non-specific '*they',* again deflecting from ascribing individual responsibility. He suggested that nurses avoided clear communications from a fear that, '*the person might react in a bad way'* [line 75]. He reported the belief that this avoidance on the part of nurses could lead a person to lack trust in their treating team, but in the end he elided stating explicitly what the result of that lack of trust may be. Oliver opted not to participate in a second interview, as he reported the first interview raised unwelcome memories. I was therefore unable to seek clarification with him about the possible motivation for his language choices.

Shirley highlighted the way in which interactions with the mental health system can compound the trauma of experiencing mental illness:

> *'Psychosis itself can be a traumatic experience, the actual scary thoughts, and then on top of that, service system related trauma, you know, the things people have said, or the time they didn't help or the time you've been in seclusion'* [Shirley, Interview 1, lines 818-821].

In her description of trauma that occurs in relation to the system, the first item she noted was what mental health workers said, that is, the trauma is caused by language. The trauma of not being helped echoes Ian's experience noted above.

Shirley illustrated an instance where she did not receive help that made her angry rather than traumatised. She had participated in the development of a resource to guide improvement in health practice, specifically through psychiatrists assuming responsibility for the monitoring and management of the long-term physical side-effects of anti-psychotic medication among the people they treated. Shirley reported her own treating psychiatrist displayed the brochure detailing the resource in the waiting room of the clinic, but then refused to implement the practice in Shirley's own care, saying '*I don't have time'.* Shirley's view was that her psychiatrist used the time constraint to mask an unwillingness to deal with the issue on a broader level:

> *'The "I don't have time" is just a "No, I don't want to deal with that, because if I deal with that with you then I'll have to deal with that with all the other people that I prescribe these things to"'* [Shirley, Interview 1, lines 745-747].

Shirley reported that, notwithstanding her prominent advocacy role and her anger at the public support for the intervention not being matched by actual practice, she felt personally unable to raise the issue or repeat the request to her psychiatrist.

Shirley also told of her dismay when she attended a conference on bipolar disorder, where the depressive phase of the illness seemed to be presented as an emerging topic for clinical attention:

> *'I know there's quite a lot of variation in how it plays out for people but, you know, the bits that are actually ruining your marriage or stuffing up your career or making your life a living hell is depression, and I just thought, the whole profession has been totally focused on the stuff when we're out of control and turning up to emergency wards and bothering the public and getting brought in by police, and that kind of private suffering hadn't been kind of prioritised or noticed on a kind of profession-wide scale, and I just was really astounded by that'* [Shirley, Interview 1, lines 645-652].

This was another example of a participant noting the invisibility of aspects of mental illness, though in this instance, it was the professionals whose role is to understand mental illness who were perceived to have missed the obvious. Shirley explicitly drew the contrast with the more visible aspects of the illness, including, '*bothering the public*', as a possible explanation for the collective myopia. A characteristic of Shirley's overall narrative was the capacity to link her own experience to broader systemic issues. This was consistent with her longstanding role as an advocate.

Shirley reported an experience of sub-optimal health treatment for a physical problem when her mental health diagnosis was raised in an emergency department:

> *'The other types of situations where the language is really important and scary is that issue of diagnostic overshadowing, and I turned up to emergency two years ago and it was the first time in my life that I've ever had sudden breathing problems, I've no history of asthma or anything…it didn't go well, you know, I said, "Well yes, I've got bipolar," and then they just, what do you call it, the triage nurse says, "Oh well", I said, "But I'm having trouble breathing", and she,*

> *she said, "Are you delusional?"'* [Shirley, Interview 2, lines 333-336 and 347-350].

Shirley also reported a negative experience with the health research system, when she sought to undertake an exploration of the influence of cultural understanding on the experience of being diagnosed with a mental illness, and was told that the particular university department where she applied was only interested in the mental health effects of diagnoses of physical illness. She presented a brief version of her analysis:

> *'You know, people get given a diagnosis of schizophrenia and then they have, like, quite a high risk of committing suicide in the several weeks after hospital, and I think personally, a lot of that's around, you know, you've just been given the diagnosis of doom, you know, which, I'm not saying it is the diagnosis of doom, but you know, culturally it is, and historically even the way medical professionals talk about it and, you know, the prognosis for it and the way it gets delivered, and you know, your life outcome assumptions are really poor, and not that the actual outcomes are like that, so people get given this horrendous kind of name, word, and there's been kind of no academic space within health psychology, as far as I can, well certainly not when I went looking, to sort of say, "Well, what does it mean to get given this word schizophrenia, and how does that affect someone?"* [Shirley, Interview 2, lines 519-529].

Shirley identified that people who have the experience of being diagnosed with schizophrenia already have cultural understandings of the illness that impact on their capacity to process the information, as these are often reductive and negative. Her stated view was that the way that this information is delivered is worthy of attention, clinically and academically.

Clinical reticence

Participants reported a special type of negative experience of language used by mental health professionals, the withholding of information about their diagnosis. This was a form of clinical reticence. On the one hand, five of the participants directly reported the experience of feeling that information was withheld from them. On the other hand, each of them was forced to question this experience, and they each came to different rationalisations for the practice. Participants expressed ambivalence about this experience. Oliver's analysis of this communication problem, where he felt that clinicians, particularly nurses, were avoiding explicitly talking about his diagnosis and treatment, was presented in the previous section, and he identified that a possible outcome was that the person feels a lack of trust in the treating team.

Nathan stated, '*It was taking a while to actually, well not to diagnose it, but for [them] to actually tell me.*' [Nathan, Interview 1, lines 260-261]. He expanded further on this, and how he perceived this use of language:

> *'It's always been, always the language that they use is very soft and placating, which to me is, I sort of feel it's almost to the point of condescension, where they don't really go through it in depth and say, here are the causes, here are the effects, this is this, this is that, so, that's been my experience*' [Nathan, Interview 2, lines 77-80].

Nathan expressed frustration, both with what he perceived to be the delay in informing him of his diagnosis, and the imprecise and superficial language in which information was conveyed by mental health workers. This echoes Oliver's suggestion that health workers don't always know what they are talking about. Nathan experienced this as being treated with condescension. When asked how he himself described his condition, Nathan responded, '*a depressive disorder with psychotic features'* [Nathan, Interview 1, line 256], that is, using clinical diagnostic terms.

Michael reported that, *'It never was talked about in a way that I could understand its presence in my life*' [Michael, Interview 1, line 189]. While he noted this, Michael did register that he lacked insight into his mental illness for many years, and it may have been this that impeded effective communication between him and mental health workers.

Ethan reported, '*I had a kind of feeling that no-one seemed to tell me what the problem was.*' [Ethan, Interview 1, line 72]. Like Nathan, he used the language of 'feeling' to convey his impression. His suggestion was that this was enacted by others as a protective strategy:

> *'I've thought, perhaps the doctors and family thought that I might get so upset by the label that I'd try and kill myself, you know, I think that it might have been a protective thing, I have no evidence of that but, you know, the way people think to try and work out things'* [Ethan, Interview 1, lines 126-129].

This is a further example of the process by which people make inferences about events in order to understand the meaning of an experience. It aligns with earlier examples where participants have reported on reconstructing their memories rather than simply recalling events. In this context Ethan reported he was trying to piece together the meaning of other people's actions, without clear evidence about the intentions behind the communications of his doctors and family. Ethan also reported very careful communication by one psychiatrist (in 'Positive experiences' section above), which serves as a reminder that people can have very different experiences in their interactions with mental health workers over the years.

INSIGHT

Insight is a key term in mental health discourse. Several participants discussed their experience of awareness that something was wrong, but lack of knowledge about what that was. For Yves, this period lasted several months:

> *'You know I probably have spent two or three months before my first onset not realising, you know, what I had or anything Andrew, and something was wrong yeah, something was wrong*' [Yves, Interview 1, lines 397-399].

This suggested the complexity of using common words with particular inferences. Yves expressed insight that '*something was wrong'*, at this point, however, he did not express insight into the fact that what he was experiencing was mental illness. Ian echoed this experience, also noting that when he sought assistance from others, he got no further:

> *'Oh, I knew something was wrong, but I could never explain what happened to anyone, it seemed like no-one, any time I explained the situation, no-one showed any sort of understanding as to what had happened'* [Ian, Interview 1, lines 112-114].

These accounts demonstrated that, prior to experiencing mental illness themselves, many people have minimal understanding of the issue, and that this lack of understanding is broadly shared, for instance, in their existing support networks. These ideas complement, rather than contradict, Shirley's observation that a cultural understanding of schizophrenia is that it is the '*diagnosis of doom'*. Both positions evince lack of understanding of the reality of mental illness.

Michael reported an extreme relationship to insight into mental illness, in the opening lines of the first interview:

> *I actually had the diagnosis before I had the realisation that there was a problem, so, what led me to realise that I did have a mental health issue was, again, being forcibly taken to a mental institution, a psychiatric ward, but this*

> *time, and that had occurred, ten, ten or so times previously, but this time around I was just, I was, I was really wondering, "What, what was putting me in this situation?" I don't know, I just didn't have the sense previously that there was anything wrong, it was just something I was going through, I didn't really, wasn't really aware that there was reasons why I was being put into a mental institution, so, I enter this ward at XXXX hospital and, I'm just puzzled by what's around me, not certain why it was happening, and I was starting to question it myself, 'What am I doing here, what's going on?', and during that stay in hospital I kind of, it's like the realisation dawned on me, with the help of a psychiatric doctor whom I'd asked earnestly, 'What do I need to do about this situation that I'm in?' and he told me that I needed to gain insight into my condition, and I had, I had written in my diary previously that people had said, 'You need insight', but it never clicked, and now with this kind of questioning attitude, puzzled by what's going on, the doctor telling me that I needed to find insight into a condition was proof that I had a condition, and that was the moment when I accepted it myself, that this was not something that doctors in a system of the medical profession was imposing on me, but there was a reason for my, you know, for this past history and present of hospitalisation, and dealing with case workers, and a whole lot of other staff, yeah, so that was that was that, and that started me on a journey of trying to understand mental illness and trying to live a life that incorporated acceptance of mental illness, but tried to reduce the effects of the mental illness on my health*' [Michael, Interview 1, lines 8-30].

In Michael's account, he was able to sustain the lack of insight into his mental illness through ten involuntary admissions to psychiatric inpatient units. He noted that he had previously engaged in explicit discussions of the term, and had even recorded it in a journal. Michael identified that the turning point depended on a combination of a mental health worker reiterating the term, and his own willingness to understand the concept. Without the latter, he had remained impervious to the idea, but it still required a psychiatrist to use the term again for it to be available for him to process, the naming of the need for insight into a condition standing as proof of the condition.

Michael went on to articulate that his own experience of developing insight contributed to a sense of responsibility to help others:

> *'I probably have a responsibility, having been through it and now taking medication that has stabilised me, that I should try to assist and advocate for*

> *other mental health clients, try and give them some insight hopefully*' [Michael, Interview 1, lines 205-208].

As the term insight was raised spontaneously by several participants during the first interview, I decided to ask everyone if the term had meaning for them in the second interview. Thus, the following responses were prompted rather than spontaneous.

Ellen stated a negative view of the word as it is used in mental health practice:

> *'See that's funny I forgot, I hate that, the lack of insight, that's thrown in my face when I'm in there'* [Ellen, Interview 2, lines 473-475].

Her choice of words was idiomatic: '*thrown in my face'* combines a metonymy, where face stands for person, and a metaphoric reification, where a concept is given form as a material thing that can be used with physical force. This is an example where the complexity of everyday language can pass unnoticed.

Ethan initially used a metaphor to describe insight:

> '*Insight is a double-edged sword I think, because if you allow it, you can develop insight and become really depressed, because, you know, it's one of those things and insight for one person is not insight for another person, so to me it's about testing hypotheses, so if you, if I think, for example, if I think I'm a political prisoner or, you know, people are out to get me or whatever, I really make an effort to rationalise it. With insight, as in knowledge of medication, knowledge of what schizophrenia is, I think that's really important for us to be able to ask questions of clinicians and actually get the best possible treatment'* [Ethan, Interview 2, lines 251-257].

'Double-edged sword' is a metaphor that infers a tool that can be useful and powerful, but also dangerous for the wielder. Ethan set out the reasons for each possibility. On the one hand, developing insight into having a mental illness can actually lead to depression. On the other hand, it can be helpful. Ethan further identified two ways in which insight can be helpful: on a personal level, it can function as a mechanism for challenging paranoid thoughts as they arise; and on a clinical level, it can provide the person with knowledge that contributes to shared decision making with mental health workers, with a view to achieving optimal treatment.

Tanya's response to the question about insight was a clear example of tangentiality; she did not provide a direct answer to the question, nor was her response completely without a link to the question, as the element she chose to expand on drew on the concept of sight:

> *'Insight, is that when you picture things in your head? I wouldn't, I don't know, I've pictured a lot of things, but most of it's been like, the sky when it turns different colours, or fish at the pond like, cause I was feeding the eel and that, and can picture the eel sometimes, swimming up and around, going up and down like a dolphin, yeah, I think because I just, kept to myself so much throughout these years and nobody, I mean insight, when like, nobody really recognised me, because I was so quiet, and yeah, I just stopped talking for about five years, and I just started like talking now, like communicating properly and stuff with people, just like, last year or so'* [Tanya, Interview 2, lines 149-157].

Halfway through the passage, Tanya reiterated the term insight, and subsequently described her previous experience of seeming invisible to other people, ironically as a result of her being quiet. While her response did not provide an answer to the question, it did convey information about her experience in the world, and her experience of language, with much of the content of her response semantically primed by the syllable '*sight'* in the term '*insight'.*

RECOVERY

Recovery is another term that has come to have specific meaning in the mental health context. This section reports the participants' own descriptions of the process of recovery in their lives, frequently occurring spontaneously in their narratives, and also their responses to a direct question about the meaning of the term in the second interviews.

A number of participants spontaneously reported strong beliefs about the influence of the experience of mental illness on their lives. Matthew stated his view outright:

> '*I feel I can honestly say that the illness that I went through has made me a better person, I really believe that Andrew, has made me a better person… I love my fellow man, I never ever want to do anything wrong, I respect the law, and I would always like to be a law-abiding citizen'* [Matthew, Interview 2, lines 151-154].

Ethan used the same term, '*better person'*, and expanded on specific aspects that he identified as being changed by his experience:

> *'The other thing is, I think I've developed and become a better person because of mental illness. So I think the mental illness is the main thing that's prepared me for the consumer work, you know, it's sort of, I'm less arrogant, I'm less narcissistic, less sense of entitlement, I feel more connected, I know what networking is, and what partnerships are, all of that. Whether I'm good at it I don't know, but others seem to think I'm doing a reasonable job*' [Ethan, Interview 2, lines 211-216].

For Ethan, there was a link between the changes he observed in himself and his participation in work to help others through the mental health consumer movement.

> *'The other thing that really helped was really not to feel superior to other people that had a mental illness, to actually see yourself as one of them, you know, so it's a bit like, "Welcome to the consumer world", you suddenly realise that they're the most helpful people of all, even more than clinicians, although there's some very good ones, and also the idea that that I can make choices you know, I don't have to be helpless, I don't have to be at the mercy of other people'* [Ethan, Interview 1, lines 178-184].

Ethan also described how long the recovery process took, and the elements he identified in his own recovery:

> *'The recovery process actually took up more time than the disintegration, as I call it, and I really, I'm pretty conscious of the kind of things that helped, being treated as a person, overcoming difficulties with family, having my family behind me, my education allowed me to detach myself, so, this is happening to me but there's an inner core where I preserve my personality, I think, [and] sense of humour'* [Ethan, Interview 2, lines 90-95].

The elements he identified include his treatment by others, but also his internal mental processes, specifically the capacity to detach himself, that drew on his experiences and attributes prior to developing a mental illness, including his education, his sense of humour and his sense of an '*inner core*' to his personality that he could '*preserve*' from '*disintegration*'.

Michael acknowledged that he had developed personal qualities as a result of having a mental illness, but he expressed ambivalence about having to experience illness in order to develop these:

> *'I'm optimistic and hopeful that, you know, it's not going to become chronic again, and it's something you don't want, you don't want to be the schizophrenic, even with all, even if it teaches you to have different values and builds your resilience, there's no way I'd want to have, no way I'd want to go through the illness again*' [Michael, Interview 2, lines 207-211].

Michael expressed a positive response to the use of the term 'recovery' in a special mental health context:

> *'Oh, as a word I like it, it means that you're improving yourself, yeah, it's much nicer than thinking that you're a schizophrenic, or have schizophrenia, "recovery from schizophrenia" sounds much nicer, but in the end it's no point having "recovery from schizophrenia" as a label for yourself if it's not actually happening*' [Michael, Interview 2, lines 348-351].

His response included specific reference to the capacity for the term to be used as a label, potentially in a positive sense, as long as it had some basis in reality.

Ellen echoed Michael's ambivalence about the experience of mental illness:

> '*I wouldn't change anything for the world, but I sure as hell wish it was easier*' [Ellen, Interview 1, lines 754-755].

However she was less positive about the use of the term 'recovery':

> *'See, that's one of my, recovery, because then it's that, that you're, there's a victim, survivor, that you've recovered from something, so it's not one, it's very rare for me to use that'* [Shirley, Interview 2, lines 418-420].

Her rejection of the term related to her perceived inference of a person having a prior history of being damaged, and was consistent with her rejection of identity descriptors that link to this concept, including '*victim'* and '*survivor'.* Tanya stated the opposite opinion, that is, that the broader associations contribute to the benefit of the term's use:

> *'It's a good word for anyone, if they've, like, you know, been through any family issues or domestic violence or I mean rape or anything like that, recovery's a good word for that'* [Tanya, Interview 2, lines 117-119].

Tanya states her own recovery in concrete, functional terms:

> '*Oh it feels great, I feel like a new person, I feel good, I feel really, really, really happy about myself, like before I was really stressed out, you know overweight,*

> *sleeping, no diet, this and that, no money, no smokes, stressing out, scabbing, bludging [laughing] sorry, but now I put money away, and [I'm] going to go see my friend in hospital, so yeah, I care for people now, cause back then I was, you know, people cared for me, and yeah, now I care for other people*' [Tanya, Interview 1, lines 168-173].

Her description of her recovery included the capacity to help others as a key attribute, a theme that recurred with several participants.

Shirley, reflecting on how her experience of bipolar disorder affected her life, was blunt in her opinion of the idea that people would not get rid of mental illness if they could:

> *'Stephen Fry's done his, you know, secret life of the manic-depressive, and he goes around and asks these people, "If you could push the magic button and get rid of bipolar, would you do it?" and you know that half, most of them say, "No, I would keep it", and I just think they're idiots, I've thought they're idiots for a long time, like, what the? I'd push it in a flash, but I think, yeah, I think, kind of, over a longer period of time there's more, I guess there's more acceptance that that's kind of been your pathway or your disadvantage or your distressing events and other meaningful things have happened because of it'* [Shirley, Interview 1, lines 410-417].

She did note that over time she has come to accept that '*other meaningful things have happened because of it'*, with the inference that some of those meanings were positive. For Shirley, meaningful things included her taking on a public role as a mental health consumer advocate, drawing on her own experiences, and identifying how these aligned with broader issues:

> *'I just think that remembering back to ten years ago, and thinking, a whole profession hasn't noticed that depression's the shitty bit of this thing, you know, and that just speaks to me that, you know, people with a lived experience aren't the central voice at the table and haven't been, and kind of need to be, no matter which kind of mental health issue or challenge you're talking about, so I guess that's my sort of particular passion around trying to centralise voices'* [Shirley, Interview 1, lines 669-675].

Shirley's use of the phrase, '*the central voice at the table'* is an example of metonymic chaining. In the first instance, the voice stands for the person, and in the second instance, the person with lived experience stands for their capacity to represent opinions about the system. The literal sense of the term also leaves its trace as those views are frequently expressed through voice. The drive toward embodied representation is further reinforced by the use of the innocuous word ‘*table*’, which creates a specific sense of spatial location.

Ian reported that he had created art specifically addressing recovery from mental illness, focused on the metaphor of a caterpillar’s transition into a butterfly:

> *‘I entered an art competition where a caterpillar has five stages of becoming a butterfly, and I did, you know, the first stages, you feel like a grub, sort of thing, you’re scraping the bottom of the barrel and you’re walking around all down and depressed, and then you realise you’ve got to do something about it so you go into a cocoon, and you develop in the cocoon and come out as a beautiful butterfly at the end of it, so I am aware of the recovery process’* [Ian, Interview 2, lines 134-139].

His description included further figurative extensions of the primary metaphor; the caterpillar downgraded via simile to, ‘*like a grub’,* and the person/caterpillar/grub then idiomatically ‘*scraping the bottom of the barrel*’, which uses predicational metonymy to convey the experience of exhausting all available resources. He went on to describe the experience of recovery in less colourful terms, highlighting the concept of ‘hope’:

> *‘Yeah that’s right, like, I believe in hope, without hope you’re really, you’ve got nothing, I mean you’ve got to have some sort of hope that there’s light at the end of the tunnel, but it doesn’t come through wishful thinking, it’s got to be a tangible end to your hope, like it’s got to actually, it’s got to be reality, it can’t just be a, you know, a wish, sort of thing*’ [Ian, Interview 2, lines 157-161].

The term ‘*tangible’* was also used by Michael, and functions as a corrective for the vagaries of inference the other senses endure in the experience of psychosis. Ian also echoed Michael’s opinion that recovery has to be real and not simply a word.

Ian also talked of the desire to help others as an aspect of his recovery. He articulated with beautiful economy the experience that lends peer work its power, *‘I was where you are’* [Ian, Interview 2, line 525], metaphorically and elliptically attributing a spatial quality to the experience of illness, and metonymically locating himself and another person in different times in that same space. The effectiveness of this blended description is not undermined by the fact that, of course, the sentence can also be interpreted literally, as there can be an actual space, for example, a mental health inpatient unit, in which the encounter occurs.

Experience of language

This last section reports on aspects of participants' experience with language that have not been captured under previous themes. The reported experiences relate to language within and outside therapeutic contexts and include further data related to figurative language.

METONYMY: QUICK QUIZ

The responses when participants were asked to determine the inferred meaning of the question, '*Would you like another glass?*' demonstrated some of the complexity involved in pragmatic inferencing and metonymy.

Yves' response evinced comprehension of the metonymic inference that would be correct in the majority of contexts:

> *'Just being hospitable and saying, you know, "Would you like another glass of water", yeah'* [Yves, Interview 2, lines 307-308].

This reading was shared by the majority of participants who interpreted the request without hesitation as meaning 'Would you like more of the contents in your glass?' That is, they made the pragmatic inference that, in the specific context, the salient concept the speaker intended to draw attention to was the metonymically inferred contents of the glass, rather than the glass itself, which is the literal referent of the term. The capacity to make the routine pragmatic inference was perhaps more notable in that the question was being asked not in the context of a social encounter where drinking glasses and their contexts were present, but in an interview which explicitly concerned language, thus potentially prompting more wide-ranging responses.

A number of participants volunteered additional information about the specificity of the contents being offered:

> *'Well, I'd be thinking Chardonnay' [laughing]* [Shirley Interview 2, line 928]
>
> *'Would you like another glass of beer?'* [Ethan Interview 2, line 382].

The question did not contain additional information about the context, and so in these responses participants were supplying likely contents, based on their real world knowledge rather than the immediate linguistic prompt, and linked through chained metonymies.

Other participants noted the ambiguity in the question, between a literal and a figurative reading. Tanya observed the possibility of a literal interpretation of the request, but, far from being troubled by the ambiguity generated, expanded on the attributes of someone who would think this way:

> *'Some people say, "Can I have another glass?" because they've already drank out of it and they'd like a clean [one], they're poshy people'* [Tanya, Interview 2, lines 244-245].

Here the desire for clean glassware metonymically stands for the type of person who might make the literal request.

Matthew struggled to answer the question:

> *P: 'Are they offering me a drink, are they offering me a drink?'*
>
> *I: 'Hmmm, is that what you think?'*
>
> *P: 'I'm trying to think, would you like another glass? I can't really connect with that, forgive me, forgive me Andrew.'*
>
> *[ ]*
>
> *P: 'As I said, it's a little bit ambiguous, doubtful in meaning, it's doubtful in meaning for me, for me it is doubtful in meaning'* [Matthew, Interview 2, lines 295-299, 310-311].

This was an example of residual difficulty with communication experienced by a person whose recovery from schizophrenia would be described as comprehensive. Between interviews he celebrated twelve years since he had been admitted to a psychiatric inpatient unit, and he does in fact have a social life which includes having the occasional drink with friends. It is worth noting that, not only did he have difficulty interpreting a phrase which is regarded as everyday speech, he found the experience disturbing and socially awkward, as evidenced by his reiteration of the doubtfulness of its meaning for him, and his repeated request for forgiveness.

While Matthew articulated ambivalence about the question in the context of a 'quick quiz', in his first interview, he spontaneously used the container for contents metonymy, responding '*two packets a day'* [Matthew, Interview 1, line 358] when asked about the extent of his previous smoking. Here ‘*packets*’ stands not just for the cigarettes contained in the packets, but an imputed standardized quantity. This in itself is underspecific, as the time when a packet always contained 20 cigarettes passed long before he gave up smoking. The point is, he was able to use metonymy in his everyday speech, but challenged by it when it was posed as a metalinguistic question.

Michael also evinced a sensitivity to the ambiguity between the literal and non-literal inferences in the ‘quick quiz’ question. This in turn was followed by a tangential response about communication problems and judgements, then recognition of the metonymic inference, and then a further comment about communication style, including clear reference to experiencing difficulty keeping track of context:

> *P: ‘Oh well yeah, if I take that literally it’s like, do I want another, I’ve got this one glass, another, it would be another one of those glasses but, [picking up glass on table]*
>
> *I: But if we’re sitting here, and I notice your glass is empty and I said, “Do you want another glass?” what would you think I’d be saying?*
>
> *P: Yeah, I’m very tolerant, yeah I allow people to talk very, with a low standard, I’m very, kind of, liberal in that sense, yeah, I try not to judge people if they can’t communicate properly, because I’ve had communication problems myself, sometimes I’ll be like halfway through a conv-, a sentence and the other person will have to jump in and I can’t even fi-, end the sentence. I try to like, think things out too much, [laughs]*
>
> *I: Is that generally or is that?*
>
> *P: Yeah that’s generally, so if you said, “Do you want another glass?” I’d know what you meant, you mean do I want another drink yeah,*
>
> *I: Without thinking about it?*
>
> *P: Well that’s the thing, I operate from a knowledge centre [pointing to chest] more than a thinking and analysing thing, yes, so often I’m caught out because in this short period something’s changed, and I haven’t really kept up with the change’* [Michael, Interview 2, lines 122-140].

Like the inferences about the specific content in the proffered glass above, these comments about communication difficulties were not directly prompted by the question, but spontaneously expanded by Michael. Michael also clearly articulated the experience of missing a contextual cue, and subsequently not being able to keep up with a conversation.

Ethan reported detecting a threat in the question:

> *'I could think of you saying that, and I could think "glassing" but just, sort of, first word in the head it triggered'* [Ethan, Interview 2, lines 384-386].

This use invokes the metonymic transfer of the object glass into the assaultive act of striking someone with a glass; this is an atypical inference, again, drawing on world knowledge not directly prompted within the provided language, and suggestive of hypervigilance.

In summary, many participants demonstrated comprehension of the intended inference of a referential metonymy with minimal context provided. Several participants formulated additional inferences, both positive and negative, based on extra-linguistic knowledge. Several participants noted the presence of ambiguity, with the presence of the source meaning not necessarily yielding entirely to the target meaning. For two participants, this ambiguity was experienced as problematic.

METONYMY, METAPHOR AND OTHER LANGUAGE PHENOMENA

This section contains salient examples of participants' use of both routine and novel figurative language. These have been selected, not because they illustrate the themes identified above, but because they furnish examples of the use of language observed by earlier researchers in mental health and linguistics. They demonstrate both skilled and idiosyncratic language competencies.

Tanya spoke of her emotional response to feathers, illustrating the capacity for metonymies to be linked together in chains:

> *'I don't like feathers because I don't like, you know, people taking them off the bird and that, I think it's sad, yeah, reminds me of death'* [Tanya Interview 1, lines 210-212].

The feather stands not just for the bird from which it was plucked, but for the bird's death, perceived as a necessary prelude to the plucking. In doing so, metonymically, she revealed a darker aspect behind what is normally imputed solely as beauty. Tanya's speech demonstrated a number of distinct language patterns:

> *'I guess when I get my own apartment, I'll take the keys with me in case something happens to Mum or I need to do my laundry, cause I've got the keys*

> *for the house, I got it cut down at the key-cutting hut underneath, on the ground floor, underneath the escalators, got them cut and it's got some sort of little fairy on it, but I keep them so that I can look after her still, like drop in time by time and if she needs food or things done, just to check on her that she's alright, to see if she's still living, breathing'* [Tanya, Interview 2, lines 47-53].

The passage begins as a discussion of her reasons for keeping keys to her mother's apartment, followed by details of where she got the key cut, and the specifics of the key ring, before returning to the reasons for holding the keys. This is a classic example of circumstantiality, where the speaker starts to include details that are extraneous to the topic, then goes further into those details, before returning to the original topic without external prompting. At the same time as close details of the spatial location of the key-cutting hut within its setting, the overall setting is not specified, which would be a more typical attribute for selection as salient. The passage ends with an example of predicational metonymy, where '*breathing*' stands for '*living*'. In this instance, the metonymic term is redundant, as she has already used the superordinate term. This demonstrates that metonymy is not always used solely to make communication more economic, but also to create inferences and nuances in meaning.

Ian used predicational metonymy in a familiar way to many of us when we can't remember an actual name, adopting salient attributes to establish the identity of a public figure:

> *'That girl, who jumped off the gap, who was on Channel Ten news'* [Ian Interview 1, lines 530-531].

In fact he ascribed two properties, as each on its own would be underspecific to identify the individual person, but both together are sufficiently specific to a listener who had been exposed to media over the relevant period. Again though, seemingly straightforward descriptions use metonymy and ellipsis to convey the full message. '*Jumped off the Gap'* elliptically described her suicide, as 'the Gap' is a common name for a specific cliff on Sydney's coastline, and jumping off it almost invariably results in death. Further, '*on Channel Ten news'* here means she was a newsreader on Channel Ten, though there is nothing in the actual words used to distinguish this from any person who may have been featured in a story on Channel Ten news.

Participants frequently used predicational metonymy, with no notable difference from the way it is typically used. For example, Ethan stated, *'I managed to stay out of hospital pretty much'* [Ethan, Interview 1, lines 76-77] where his ability to stay out of hospital stands for his actually doing so. Ethan also stated, *'you might need to jog my memory'* [Ethan, Interview 2, line 9], and again, the insertion of '*might*' almost passes unnoticed. The fact is, he did need to be reminded, but he refers to this as a potential rather than a real state. Other participants also used this type of metonymy, for example, Tanya, when asked how she describes her experience, stated, *'I'd have to say I've got schizophrenia'* [Tanya, Interview 1, line 121] with obligation to say standing for actual saying. Similarly, Nathan stated, *'I was able to be released'*, and Matthew used *'I must admit'* [Matthew, Interview 2, line 118]. Participants demonstrated use of predicational metonymy in their speech production without any of the opacity or atypical use that was occasionally noted in their use of referential metonymy.

Ellen's speech also featured a range of uses of distinctive linguistic practices, including reported speech, repetition, and mixing of elements from different discourses:

> *'When XX, my now ex-husband, called and said, "Ellen has been hit by a car and she can't come in to work today." my manager said, you know, "You're joking, right?", she just didn't believe him because we had discussed, like that morning I came in, we talked wedding and Christmas, and then we focused on vision and strategy and you're all on the same page and she said, "I took a deep breath." and I thought, I can't believe it, this is everything I've worked towards is here, here and now, yay, three minutes from home, you know, stepped off a bus, crossed the street, I remember the green walk sign, and that was it, my life changed'* [Ellen, Interview 1, lines 354-361].

In the first instance, she used direct speech to describe a telephone exchange between her then husband and her manager, even though she would not have been able to hear, let alone recall the exact words 12 years later. She then takes a step back chronologically, and narrates the morning prior to a car accident, and her description used terms drawn from corporate discourse, '*vision and strategy'* and '*on the same page*', the latter an idiom in which people observing the same page in a document (which may be real or metaphoric) metonymically stands for people being in agreement. In the second-last line of the passage, Ellen used a predicational metonymic description for the location of an accident, '*three minutes from home'.* It is clear that she was describing the place, that is, the location in space where it occurred, as the other descriptors are consistently visuo-spatial (e.g. '*green walk sign'*). But she did not state, '200 metres from home' which would be the literal means of conveying location information, but instead metonymically substituted the estimated time to walk that distance to describe it. This is an example of a type of metonymy that is so deeply ingrained within the everyday way of conceptualising time and space that it generally passes unnoticed.

Ellen described being placed on a community treatment order as *'I had to go through parole'* [Ellen, Interview 1, line 233], ironically equating the legal obligations placed on her for some duration to the legal force placed on people who have been convicted of a criminal offence and subsequently released from prison. This is a clear instance where the trace from the source is intentionally foregrounded in naming the target. While offered ironically, this term clearly indicates that being subject to mental health legislation is experienced as equivalent to being punished as a criminal.

Michael used another frequently encountered concept, the metaphor of an illness being a *'journey',* several times and when asked to speak further about it, stated,

> *'Well it's just change, I mean, even looking back before I became unwell, it was a change becoming unwell, so it was a journey even though it was an unwanted journey, travel through that'* [Michael, Interview 2, lines 224-226].

This demonstrated that, while his initial use of the metaphor may not have been overt, he was readily able to expand on potentially available inferences in its use. For instance, he noted that '*it was an unwanted journey*'. This is an example of use of figurative language where there is a disruption between the source and the target, as the presumptive inference is that a 'journey' is undertaken voluntarily, thus requiring the addition of a qualifying adjective. He then metonymically extended the journey metaphor by saying, '*travel through that'*, which incorporated the idiomatic sense of overcoming adversity as getting through something. Soon after, he offered a further observation on the ways that people can conceptualise the experience of illness:

> *'Well I don't know like, archetypes and Joseph Campbell type stuff, everyone has their own story, they're the hero in their own story, maybe that's not cool to call it that, that's how I perceive it' [laughing]* [Michael, Interview 2, lines 230-232].

Michael linked his use of the term '*journey'* to the writings of the mythologist Joseph Campbell, suggesting a pattern of deeper reflection in his choice of the term.

Michael used the only example of illocutionary metonymy, when he spoke about his relationship with his mother, he opened with '[*I] should probably mention my mother as well'* [Michael, Interview 1, line 102], where the presumed obligation to speak about his mother stands for him speaking about her.

NARRATIVE

Examples of participants' use of different narrative modes have been noted within previous sections. This section reports on participants' varied, and occasionally contradictory, ideas about narrative.

Three of the interview participants have worked in roles where they have previously narrated their experience of mental health issues and subsequent treatment in various instructional contexts. These include presentations to other people experiencing mental health issues, to practising clinicians and students in undergraduate courses, and to audiences of first responders, for example, police and welfare workers.

For other participants, narrating their stories was a novel experience. At the end of the first interview, I asked Tanya, '*Are there any other stories that you want to tell?'* Her response subverted my inference that the story be about her experience of mental illness or recovery:

> *'Well I, I found these, I found a dead mynah bird in my front yard, and five years ago I found another dead mynah bird in the lion head pond, I go there because the lion is my star sign, and I used to put flowers in there. Anyway, they're five years apart and they're both buried in the backyard. I went up to the lion head pond and I put a flower in there the other day, then like, the next week later I went back to put another flower in there where I found the first mynah bird, and the other flower was still there, fresh, because it was in water, yeah, and I was, when I first buried them, they're five years apart, I put flowers on their grave and stones around it, and covered it with stones, yeah'* [Tanya, Interview 1, lines 192-200].

Instead, Tanya offered a brief narrative, outlining her relationship to nature and space. The *'lion head pond'* is a specific place, with a stone replica of a lion's head as the outlet for a fountain. Speaking of her motive to go there as linked to her star sign indicated an intensely personal relationship to meaning, the linking of the salient elements functioning as motivation for action, not just description. The passage also demonstrated her relationship to other life forms, with near magical thinking, as in the flower staying alive in the water for a week, and the linking of the two dead birds over five years. Her respect, in arranging tributes to the dead birds, was also evident. The whole passage spoke of a life where her experience is invested with meaning.

For Ethan, narrative itself functioned to create meaning from experience. He linked the concept of deliberately crafting a narrative to create meaning, metaphorically conveyed as '*weaving'*, with having insight, thus making insight a dynamic process rather than a fixed state:

> *'It's also very useful to reconnect the chaotic last forty years into some kind of narrative or story, and if you don't have insight, I mean, in that sense of weaving together your life into some kind of meaningful thing instead of a slag heap, it's very difficult'* [Ethan, Interview 2, lines 259-262].

Ethan is one of the participants who has undertaken consumer advocacy work that includes the use of his own narrative with different audiences. He described the process as always evolving, in that, in reconstructing his story for new purposes, he discovers additional meaning which he incorporates into his own process of recovery.

Shirley has also retold her story publicly, but her reflections on the process were different from Ethan's, extending to a reflective critique of this use of narrative:

> *'There's some people who are really trying to talk about this idea out of Canada, called, "patient porn", which I think is just fantastic and I use it to critique my own kind of storytelling: "At what point is the telling of these experiences just simply kind of spectacle?" and that's something I've been thinking of a lot actually at the moment'* [Shirley, Interview 2, Lines 859-863].

Her account shared with Ethan's a sense of narrating past experience as a dynamic and reflective process. However, her question rested more on the role that these narratives play for the audience rather than for her, with details of her life offered up for voyeuristic consumption. Shirley linked this in part to a frequently observed phenomenon whereby narratives serve explanatory functions:

> *'People have this innate need to make sense of it [mental illness] and attribute it to something, which I'm actually not that interested in to any, I've got about ten percent interest in that, relative to other people's 100% interest in that, so that sense-making process is important to other people, and the attribution of cause seems to be very important in, to people at large I've found, so in my work I definitely use things like, "Well, there were a range of things going on"'* [Shirley, Interview 2, Lines 749-754].

As part of her reflections on her story and the purposes to which she can put it, and to disrupt what she saw as other people's narrow interests, Shirley adopted a dual strategy, suggesting a multiplicity of factors that influence developments, rather than a single causal element, and then underspecifying those factors within her narrative of her own past, using the deliberately vague term, '*a range of things.'*

Ellen articulated a tension inherent within a narrative interview in relation to what is sought: an answer to a question, or a narrative? '*I also forget what the hell you ask me because I go into my story*' [Ellen Interview 1, lines 334-335]. Her response reflected the idea that her story exists on its own terms, and she tells it in that way, rather than it being constrained to be 'fit-for-purpose'.

PARTICIPANTS' OWN OBSERVATIONS OF THEIR USE OF LANGUAGE

Ellen described having a longstanding interest in language, and commitment to using language deliberately in order to communicate well. She reported a response she once received from a vocational worker to her impressive vocabulary: *'Did you swallow a dictionary when you were a kid?'* [Ellen, Interview 1, lines 744-745] and she described always making conscious choices in her language production:

> *'When I engage with someone initially I ascertain, like, use different words, and I'll say, "Ooh great, oh great I can use my vocab," or, you know, just simplify it, and I'll always check in with someone 'cause I don't want to, I'm not interested in dumbing down language, but it's about what someone's comfortable with'* [Ellen, Interview 2, lines 145-149].

She talked about the importance of using skilled communication in her interactions with mental health workers: *'I need to be able to articulate in a way that I am taken seriously and not seen as a number'* [Ellen, Interview 2, lines 88-89]. In doing so, Ellen challenged the practice of referring to health care recipients as numbers. Ellen also reported that, alongside her practice of checking that other people can understand her speech production, she is also comfortable seeking clarity when listening to someone, ensuring her speech comprehension:

> *'I don't make assumptions, if it doesn't, if it doesn't flow on with what's being discussed, if it's just something different, I'll check in, I don't have any issues with clarification'* [Ellen, Interview 2, lines 249-251].

Ellen reported her evaluation of the result of this care in communication:

> *'I know that people trust me because of my use of language, and everything that goes with that*' [Ellen, Interview 2, lines 238-239].

In Ellen's assertion that people trust her, her '*use of language'* is both the salient element in itself, but also stands for '*everything that goes with that',* its power thus operating both literally and metonymically.

Other participants reported awareness of difficulties they experience with language. Michael has achieved significant control of the positive symptoms of hallucinations and delusions. He is motivated, has studied at university, works and has spoken publicly, at times in front of audiences of 200 people. Nonetheless, he experiences communication difficulties:

> *'It happens to me a lot of the time, like, I just don't have anything to say with people that I'm with, and then when I do say, it's in some sort of vague general way that, I just give up sometimes talking. Yeah, so that, I think I haven't really honed my communication skills because of the psychoses, and the illness for like, a decade, so I'm just trying to pick up the pieces and improve*' [Michael, Interview 2, lines 329-333].

For Michael, his experience of problems with speech production is related to his experience of psychosis over more than a decade, with the implication that it is specifically a problem of social skill. His experience echoed Tanya's report that she '*just stopped talking for five years'.* Michael's response to an earlier query whether he ever had the experience of not comprehending another person's sentences or phrases revealed a rigid concept of language, '*Well, that's what the dictionary's for'* [Michael, Interview 2, line 120], suggesting that his self-reported problems with language may not be restricted to lost opportunities in the social realm, but may also include a language processing issue that impacts directly on his capacity to form pragmatic inferences. This is reinforced by his earlier report of not keeping up when meanings change in specific contexts.

Yves recounted an episode of communication difficulty he experienced as a mental health inpatient:

> *'Talking to other people in hospital sometimes we're all off track, so we're all off track with each other, so we're having, heaven knows what we're having delusions of, and we're all sort of talking off the air'* [Yves, Interview 2, lines 243-245].

His report was of people concurrently experiencing derailment. Asked how they responded to this situation, he explained:

> *'Oh, you sort of like, go and have a smoke together or something but you just don't really notice it, you notice it but you just ignore it, you just sort of, it's just part of the, sort of, lifestyle'* [Yves, Interview 2, lines 337-339].

Yves reported a generally good-humoured response to this, '*hav[ing] a smoke together'* metonymically suggesting the breakdown in communication did not necessarily lead to a breakdown in friendly relations. When asked if he thought there was a benefit in clinical staff drawing attention to derailment when it occurred, Yves firmly expressed the view that it would not be useful.

Shirley's ideas on language use in recovery also included an important distinction between language used with peers and language used with mental health workers:

> *'One of the most critical things in that was language actually, because about 18 months prior to that I'd spoken to someone who'd had some similar experiences, and they referred to those types of experiences as 'scary thoughts', and I just kind of, I started to use language, just internally, that just tried to stop using the catastrophe language and stop seeing it as a crisis and stop seeing it as psychosis and I tried to bring it down to, sort of, matchbox size and go, "You've just had some scary thoughts"'* [Shirley, Interview 2, lines 900-906].

Shirley accorded language a significant role that recalled the function of narrative for other participants, speaking of '*sense-making'* where others had used the term '*meaning'.* Shirley expressed the complex idea that language cannot adequately capture reality, yet it may contribute to shaping reality:

> *'I think that some of the language we use just isn't powerful enough for some of the experiences we have, and then I think, just that idea that people can be supported and encouraged to explore language use for themselves as part of healing, you know, as part of sense-making of what's happened, and you know, I did have what I think is the equivalent level of intense experience last year as I did fifteen years ago, but one of the big differences around bouncing back from that has been my ability to shrink it down using language, and my experience making sense of it through conversations with peers, not with health professionals, and just my own reflection on that'* [Shirley, Interview 2 lines 994-1001].

In particular, Shirley spoke of being able to '*shrink down'* the intensity of an experience through using language. By using the term '*ability*', Shirley highlighted that her use of language was something she could control, and that this could in turn contribute to her capacity to control her responses to her psychotic experiences.

Shirley, through her strategic use of language, further demonstrated a purpose that went beyond her own situation, when she articulated an effective argument about the responsibility that psychiatrists have to monitor the physical health of the people they treat:

> *'If your pen's going on that prescriber's pad, you are the one that needs to read the journals about the physical health impacts, and you should know what's going on with my kidneys, or my whatever, my metabolic rates and stuff like that*' [Shirley, Interview 1, lines 712-715].

The '*pen [ ] on the prescriber's pad'* struck me as a powerful use of metonymy as soon as I heard it in the first interview. The responsibility inherent in the practice of treating mental illness, from diagnosing to treating, was metonymically reduced to one salient aspect, applying a pen to a prescriber's pad. When, in the second interview, I asked Shirley to comment on her use of this term, she reported that, in her role as a consumer advocate, she had been asked several times to provide comment on mental health issues to the press. Shirley reported she had been told by one journalist, '*I can give you two sentences, maybe three.*' [Shirley, Interview 2, lines 833-834], so she learned to make her communication more economic. In this context, her use of the phrase proved successful. This relates to the original role of metonymy in rhetoric, to persuade.

Conclusion

The information provided by participants demonstrates complexity both in their experience of mental illness, and their experience of language. At times, complexity arose from the intersection of these experiences.

METONYMIC INFLUENCES ON PARTICIPANTS' EXPERIENCE

The influence of metonymy was demonstrated across several aspects of participants' experience. Participants discussed their thoughts about identity; all reported they had thought about the topic, and for all participants, the experience of being diagnosed with a mental illness influenced their sense of identity. For some, there were benefits to this, and several participants spoke about how they felt their experience of mental illness had made them better people. Participants also reported that having a diagnosis gave them a sense of control. For others, there were negative aspects to adjusting to living with a mental illness, and the necessary realignment to their previous sense of self. These aspects had material consequences in people’s lives, influencing their interactions with others, and their capacity or willingness to accept treatment.

One strategy participants reported to address this risk was reclaiming other attributes as significant in their identity formation. These included resuming roles like caring for family members, working, studying and undertaking peer advocacy work. These strategies were related to a key concept underpinning identity, visibility. While participants reported their identity formation involved self-reflection, it was also strongly influenced by the image of themselves that they saw reflected by others. In this context, it follows that undertaking socially recognised activities like working and helping others supports a positive sense of identity. Other participants reported that it was the invisibility of their symptoms that led to people not understanding, or otherwise underestimating their experience of illness.

All participants reported experiencing stigma. This was frequently, but not exclusively related to the perception that they had a mental illness. Both participants who were first diagnosed with mental illness in the 1970s expressed the view that stigma is getting worse.

Participants reported negative experiences, including poor communications, with mental health workers. In particular, they reported the experience of not being listened to, and having their explanations of events, and their wishes and values discounted. Participants reported being denied services as a result of their mental illness, and conversely, as a result of their mental illness not being recognised. This included having physical problems undertreated or dismissed when their mental health history was noted. These forms of discrimination are based on stigmatising attitudes about what people who live with mental illness are like, and the credibility of what they say.

Participants also reported positive aspects of the mental health treatment they had received. Positive elements included workers who fully engaged with them as whole people, without foregrounding their mental illness. This worked in reverse as well, with participants noting the best interactions were with health workers who acted as whole people themselves, not restricted to their clinical roles. This engagement was frequently evident in the language that was used in clinical encounters, as reported by participants.

METONYMIC ASPECTS OF PARTICIPANTS’ LANGUAGE

In terms of speech comprehension, participants demonstrated the capacity to interpret metonymic speech used by others, including the metalinguistic capacity to play with the language. Participants demonstrated their enjoyment of this capacity to juggle multiple potential intended meanings. Several participants demonstrated difficulties with comprehending figurative language. In relation to speech production, several participants also demonstrated idiosyncratic speech patterns, including elements suggesting the presence of thought disorder. The presence of these difficulties created material effects on people’s lives, with some participants reporting they ceased or reduced communication with others because of these problems.

When describing their symptoms of mental illness, participants frequently used figurative language to convey their experiences. They also used narrative skills in telling their stories.

Participants demonstrated critical awareness of the language used about mental health in general, and themselves in particular, in the language they encounter from mental health workers and the broader community. They have also demonstrated strategies to manage the influence of this language. The experience of language as reported by people who live with mental illness will be explored in relation to previous literature in the following Discussion chapter.

CHAPTER 6: DISCUSSION

Two research questions were introduced at the beginning of this study:

> How does the use of metonymic language influence the experience of people who live with mental illness?
>
> How does metonymy influence the speech production and speech comprehension of people who live with mental illness?

The ubiquity of metonymy in everyday speech (Lakoff & Johnson 1980; Littlemore 2015) was evident in the language experiences reported by participants. Metonymic language is used by them, and about them. In particular, the influence of labelling, previously identified by social theorists (Goffman 1963, 1968; Scheff 1974) is still prevalent. Labelling enacts metonymy, and although these concepts have not previously been linked in the literature, the data from the interviews demonstrated their co-occurrence.

The evidence from participants' narratives will be considered in light of previous literature. Mapping the influence of metonymy on participants' reported experiences, the chapter begins with a discussion of identity, which was an *a priori* theme for the study. The way in which identity is metonymically constructed through the selection of specific attributes is addressed. This is followed by a discussion of participants' description of the visibility or invisibility of mental illness, underlining that identity is constructed within a social context. In cognitive linguistic terms, the visibility/invisibility distinction rests on the process through which an aspect of a phenomenon is metonymically selected for foregrounding. This concept is considered alongside literature about marginalised groups for which membership status is not necessarily obvious. The following section addresses the experience of stigma, which was reported by all participants. This includes reported experiences of poor treatment when accessing health services, which participants perceived to be related to their mental illness. In this context they also reported some uncertainty about the inferences they drew from their experiences. This uncertainty is related to the way in which metonymy can mobilise two meanings at once, a literal and a figurative one, each of which carry different potential inferences. The chapter then addresses participants' reports of their experience of symptoms, which echo previous suggestions in the literature about possible metonymic motivation for delusions.

The words that participants use to describe their symptoms demonstrate figurative language, and this leads into a section on metonymic influences in the speech production and comprehension of participants. The evidence for the concept of metonymic speech in psychosis, first put forward in the 1930s, is considered. An exploration of participants' speech comprehension follows, followed by a discussion of the range of uses of metonymy in participants' speech that are consistent with everyday language practice in the broader speech community. The metonymic strategies that underpin the function and operation of narrative in participants' interviews are identified.

Finally, the chapter addresses the study's contribution to cognitive linguistics, the limitations of the current study, and its implications for research and practice. The conclusion draws together the concepts explored within each research question.

The influence of metonymic language on the experience of people who live with mental illness

Participants reported that the way that language is used and interpreted in the varied contexts of everyday life and in clinical encounters has a marked effect on their experiences of living with a mental illness. The broad answer to the first research question is that the influence of metonymic language is experienced in both positive and negative ways.

Participants made inferences about the world as they experience it. They reported that, in turn, inferences were made about their language, their appearance and their history, by clinicians and others. These inferences had material effects in their lives, including the experience of services being delivered coercively, or being withheld. Metonymy underpins this pragmatic inferencing; in some cases participants selected which attributes or elements of a situation would be foregrounded, and which would be relegated to the background. In other instances, they reported these processes being enacted by others.

IDENTITY

The onset of mental illness typically occurs in early adulthood, and the novel experiences can radically alter people's sense of self, and expectations for the future (National Mental Health Commission 2014). This is also a period when people are questioning their identities, often contesting premises about identity based on membership of social categories. Gender, sexuality, class, political and religious beliefs are some of the attributes that can be foregrounded in people's sense of self, as can the experience of illness. Each of these categories can be embraced or resisted (Butler 1990).

All participants reported that identity was an important concept for them and that incorporating the experience of mental illness into their identities had proven a challenge. They reported having little or no knowledge about mental illness when they were first diagnosed, and frequently their images of what it meant to experience mental illness were overwhelmingly negative and stigmatising; as Shirley put it, '*you've just been given the diagnosis of doom'.* This lack of knowledge, and subsequent fear, was typically represented as shared by their families and social networks. At the same time as they were attempting to incorporate knowledge about mental illness into their identities, they were also relinquishing their previous sense of identity, built on attributes such as intelligence and competence, and marked by badges of success including jobs and relationships. Viewed cognitively, the onset of mental illness metonymically displaces other attributes, whether they will it or not.

Participants spoke of identity in different ways. For some, identity was significantly constituted through specific attributes, while for others it existed independent of such ties. The functional role of identity as a factor explaining the motivation for social action was reported. A powerful identity narrative articulated spontaneously by several participants was that, although they did not enjoy all aspects of experiencing mental illness, they believed that the experience had made them better people. They reported that their sense of identity became stronger and more compassionate because of their experience of dealing with the adversity of mental illness. They spoke of these changes in abstract terms including values, beliefs, and resilience, but they also reported developments in pragmatic terms, including the renewal of their capacity to care for others. This practice enacted values that were important to them internally, but also involved performing a role that was visible to, and validated by others.

Participants described a path, from reluctantly accommodating a stigmatised element in their identities, towards accepting the value the experience has added to their lives. The participants in Barham and Hayward's (1991) study of people living with mental illness in the first decades post de-institutionalisation voiced similar changes in their values, including a shift from desire for money and material things to a greater appreciation for self and recognition of others. This shift is paralleled by reports from other groups who have received diagnoses that carry stigma:

> HIV-positive interviewees described the identities that took them over after diagnosis as fabricated out of stigma, but progressing towards acceptance, even affirmation, of their condition, and towards an enhanced awareness of what is important in life (Squire 2000, p. 200).

The process of being negatively identified by means of their mental illness was subsequently overridden, as the manner in which they have met the adversity became an attribute available for selection in the formation of positive identity. A further successful strategy reported by participants was to incorporate the experience of mental illness into one's identity, and highlight the positive value inherent in overcoming adversity. Michael expressed this as the capacity for everyone to be the hero of their own journey. These comments resonate with those of the former National Mental Health Commissioner, Janet Meagher, (2014, p. 8) who recently stated:

> Anyone who can find their way through the personal mess and the emotionally charged losses that accompany a life lived with schizophrenia, is, in my judgement, a real hero. The singular effort and courage involved in living and surviving from day to day is, without exception, a hero's journey.

Participants' descriptions of their identity also voiced cultural understandings of the concept, in particular structural ideas that posit a 'core' at the centre of identity. In tracking the historical development of these ideas, White (2007, p. 102) has identified that they include:

> The evolution of the concept of a "self" is an essence that is understood to occupy the centre of a personal identity. Although this idea of a self is a relatively novel idea in the history of the world's cultures, it has been a hugely successful idea and is today quite taken for granted in the West.

As Flaskas (2002) has noted, however, while critique of such structural notions of identity may support therapeutic approaches, for many people, maintaining a coherent sense of identity is a more important goal than challenging philosophical ideas about selfhood.

The narratives demonstrated that participants had given thought to the idea of identity, and adopted a number of strategies for incorporating the experience of living with mental illness into their own senses of self. They also demonstrated that identity formation is not simply a process of self-selecting which aspects they consider to be significant about themselves, and foregrounding these. Rather, identity is a concept that exists within a social context, mediated by contending forces beyond deliberate control of any individual or group. Within this context, the metonymic process by which salient attributes are identified for attention, with consequent influence on the inferences drawn, was described by participants in terms of visibility.

VISIBILITY

For most of the participants most of the time, the fact that they had experienced mental illness was not discernible to others. This unmarked status carried both benefits and problems. Shirley and Ian both noted that the extent of the suffering people experienced from mental illness was invisible to the general community, and that the courage it takes to deal with mental illness was rarely afforded the kind of recognition that people coping with physical illness receive.

In this context, participants frequently contended with decisions about whether to reveal their experience of mental illness or not, to '*put a pole up and raise the flag,'* in Tanya's words. Michael, Ethan and Shirley have each made the decision to undertake roles as public mental health peer advocates. Having once chosen to reveal their experience in the public domain, they no longer control who can or cannot know.

In terms of both identity and visibility, these experiences align with the 'Person (mental patient) / Mental Patient (person) predicaments' previously identified by Barham and Hayward (1991, p. 144). Negotiating these predicaments entailed ongoing decisions for participants about which aspect of the self should be chosen for highlighting in any specific context. In cognitive linguistic terms, a speaker can choose what is the focus of attention by metonymically foregrounding a specific attribute of an entity (Talmy 2007). The decision to reveal, or not reveal, an aspect of oneself enacts Langacker's (1993) concept of reference-point phenomena. Selecting what the reference point will be determines the inferences that are drawn. The operation of cognitive processes in the focussing of attention was described more than a century ago:

> But we do far more than emphasize things, and unite some, and keep others apart. We actually <u>ignore</u> most of the things before us (James 1890/1950, p. 284, underline in original).

What people choose to attend to and what they choose to ignore each contribute to an understanding of the issues identified by participants. A further aspect of the predicaments identified by Barham and Hayward (1991) is that, notwithstanding the selection of one attribute for attention, elements that may subsequently be shifted to the background nonetheless leave a trace, intended or not. This aligns with the potential for metonymy to be ‘an efficient way of saying two things for the price of one’. (Brdar-Szabo & Brdar 2011, p. 236). Barham and Hayward (1991) stress that it is important to maintain awareness of the difference experienced by people who live with mental illness, and not elide recognition of this, even as their personhood is foregrounded. Metonymy contributes to the cognitive capacity to maintain this dual awareness.

Participants reported many situations in which it was not clear if their experience of mental illness were known or not known to others. Moreover, this opacity extended to whether the knowledge would have a functional outcome. Participants in Barham and Hayward’s (1991) study similarly spoke of the sense that other people probably knew they had mental health problems, and that this was not an issue when, for example, they were meeting for a drink, but would become an issue, albeit not openly acknowledged, if they were to apply for paid employment. In this light, participants’ reported experiences of work are illustrative. Nathan enjoyed the mark of a specific role ‘*as a roadie’* in which his experience of mental illness was not a factor. Shirley, on the other hand, masked her mental illness behind office banter in order to retain her job, a mask that was reportedly so successful with colleagues it marked her as the type of person who it is presumed cannot have experience of mental illness. She described this experience as ‘*passing*’, and expressed clear recognition of the benefits and risks involved. Her capacity to present as chatty even when depressed functioned as a protective factor; however, it also exposed her to hearing stigmatising attitudes expressed by fellow employees toward others with mental illness.

Passing has a long history with members of other marginalised groups who may not immediately appear to belong to a marked minority. At the turn of the twentieth century, the term was used by people of African descent who were light-skinned, and would selectively ‘pass’ as white for various social ends. This phenomenon was explored in the novel *Passing* (Larsen 1929). Butler (1993, p. 170) makes explicit the complexity of how passing functions in that specific narrative, and more generally:

> Blackness is not primarily a mark in Larsen’s story, not only because Irene and Clare are both light-skinned, but because what can be seen, what qualifies as a visible marking, is a matter of being able to be read a marked body in relation to unmarked bodies, where unmarked bodies constitute the currency of normative whiteness.

Thus, an attribute such as skin colour, metonymically connoting race, may or may not be noted, depending on its importance in the context of marking it as other to the norm. Whether an attribute is attended to or not depends on factors other than the degree of difference it embodies, and this attention may be influenced by social or political categories that may be mobilised strategically to further particular interests.

Passing has historically allowed people to avoid the explicit persecution directed at other members of their communities. This bears out Goffman's (1963, p. 74) comment:

> Because of the great rewards in being considered normal, almost all persons who are in a position to pass will do so on some occasion by intent.

Passing has also been practised by members of the Lesbian, Gay, Transgender, Bisexual and Intersex (LGTBI) communities, whose status may be marked or unmarked, but has traditionally carried the risk of stigma and violence if known. A strategy adopted within these groups was to present in public accompanied by a member of the opposite sex, thus creating a presumption of heterosexuality. These companions were known as 'beards' by insiders. Hardie (1999) has analysed how the term beard originates as a metaphor for natural masculinity, and is then metonymically deployed, as 'standing for' heterosexuality, and available to both gay men and lesbians.

Ethan reported adopting an alternate series of what Goffman (1963) termed 'spoiled identities', including drunk, dropout and hippy, as all were preferable to being '*seen as a lunatic'*. Ethan's assessment was that the strategy failed, and that '*people thought I was crazy as well as drunk'.* Ethan's strategy directly enacts a process formerly identified by Goffman (1963, p. 94):

> Another strategy of those who pass is to present the signs of their stigmatized failing as signs of another attribute, one that is less significantly a stigma.

In a similar way to the 'beards' formerly used by LGBTI people, the use of these substitute identities operated in a dual way. The strategies Ethan mobilised to disguise the devalued attribute of mental illness actually drew attention to their deployment as disguise. This reinforces the idea that the selection of a particular attribute for attention is not a straightforward matter, and is often determined by other social forces operating within the context.

STIGMA

All participants reported experiencing stigma. This included having services withheld or delayed, services delivered coercively, and services delivered without clear explanations being shared with participants. Participants also reported self-stigma.

Stigmatising language frequently made explicit the link to participants' perceived mental illness. Two of the terms cited by participants that were used against them with hostile intent, '*loony'* and '*psycho',* are shortenings of terms that have been, or still are, used clinically, '*lunatic'* and '*psychotic'.* These terms have undergone a transfer in inferred meaning as they have moved from clinical to common, typically negative, usage. Invoked as slurs, these terms draw a significant measure of their derogatory power from their association with the legitimacy of the clinical judgement practised by psychiatrists.

Participants' narratives confirmed the findings of Reavley and Jorm (2011), that there is still widespread stigma in the community against people with mental illness. Moreover, this stigma remains more pronounced against different diagnoses, with people with schizophrenia being the most stigmatised, borne out by the psychiatrist's reported comment to Shirley's mother that, '*you're lucky she doesn't have schizophrenia'.*

In this context, Ian's suggestion that if schizophrenia were called a '*nice name…like brainiac'*, then people would hold less stigmatising attitudes toward people with the diagnosis, while made humorously, actually calls up serious arguments about the influence of language. The issue of whether diagnostic terms are in themselves stigmatising arose several times in participants' reports, including Ian's dislike of the prefix '*schizo*'. Bleuler's (1911/1950) attempt to distance schizophrenia from the previous stigmatising association with dementia (Fusar-Poli & Politi 2008) itself yielded to stigma one hundred years later, as evidenced by calls for the term to be abandoned altogether (Kingdon et al. 2007).

Shirley expressed a more sceptical view, '*that stigma follows you round whatever language you use'.* Her assessment that stigma operates regardless of the terms used aligns with the findings reported by Tranulis and colleagues (2013), that the benefits of changing the name for conditions is attenuated over time as society comes to understand the correlation with the previous term.

Stigma has been comprehensively challenged in recent decades with a number of previously marginalised social groups collectively asserting their rights for recognition, and rejecting the status quo wherein their perceived attributes were used to justify lesser rights. The statement ‘The personal is political’ (Hanisch 2006), popularised within the feminist movement, was a catch-cry of people advocating for change by foregrounding the salient elements that had previously been used to justify oppression of certain groups. This was a converse approach to the earlier strategy of passing, and it was members of many of the same groups who had once sought social advantage by masking their stigmatised attributes who now adopted the reverse strategy, under the banner of ‘identity politics’.

A powerful strategy used by these groups has been to take the metonymic identifying terms used by others about them, and re-appropriate them, making them a badge of pride. ‘Nigger’, ‘faggot’, and ‘slut’ are all words that have been used in this way. It is always a contested strategy, with some members of the groups in question rejecting the terms as perennially harmful. Mad pride is the most visible group within the mental health consumer movement who have utilised these strategies, reclaiming the term ‘mad’ in preference to diagnostic terms (Dellar, Curtis & Leslie 2000). While several participants challenged negative stereotypes about their capacity or dangerousness, none of the participants in the current study adopted this particular stance, and several commented that they themselves don’t loosely use terms such as ‘crazy’, and don’t like it when others do. This demonstrates deliberate language choices, used to distance themselves from stigmatising positions.

SELF-STIGMA

A specific form of stigma is self-stigma, or internalised stigma. This occurs when people regard themselves as members of a group and endorse stigmatising attitudes toward the group that are held more broadly in the community. Ethan observed that, ‘*Insight is a double-edged sword’*, that is, it can help in gaining control of your symptoms, but, if you hold negative ideas about mental illness, it can also result in low self-esteem and poor mental health outcomes.

The strongest example of the effects of self-stigma was Ian’s reported non-adherence to treatment for schizophrenia for twenty years, with multiple involuntary admissions to hospital and a great deal of suffering. Subsequent to his diagnosis being reformulated from schizophrenia to bipolar disorder, he reported improved adherence, even though this involved him taking the same medication he was previously prescribed, as well as an additional mood-stabilising drug. The result of this improved adherence was an improvement in Ian’s control of his symptoms. This demonstrates the dual operation of literal and metonymic language and thinking (Littlemore 2015). On the literal level, the re-diagnosis and addition of a new pharmacological agent contributed to the improvement in his mental state. But in Ian’s telling, the metonymic shift in meaning that he attributed from one diagnosis to the other, that is, what each stood for in relation to his sense of identity, was integrally tied to his willingness to adhere to the treatment, and consequently resume better control of his illness.

Lysaker and colleagues (2006) explored self-stigma in a study in a large psychiatric hospital. They found that a significant proportion of people with schizophrenia expressed good insight into the fact that they had a mental illness, but also internalised stigmatising attitudes about mental illness. For this group, outcomes in terms of their mental illness were worse than for those who either had minimal insight, or those whose insight was not accompanied by negative attitudes toward mental illness.

Corrigan and colleagues (2013), drawing on research that demonstrates the benefits that accrue to LGBTI people when they ‘come out of the closet’, that is, disclose their previously invisible sexuality, developed a program using a similar technique to support people who live with mental illness to weigh up the costs and benefits of disclosing in various contexts. The program was subsequently tested in a randomised control trial (Rüsch et al. 2014), with participants reporting reduction in the stress related to self-stigma.

STIGMA FROM HEALTH WORKERS

Participants reported their perceptions of stigmatising attitudes held by health workers in both general and mental health settings. Shirley reported an incident when her acute respiratory distress was dismissed as delusional. Ian reported that after a suicide attempt, staff stitched his wounds, but did not address his mental distress. Yves reported anti-cholinergic medication being withheld by clinicians on the basis of his past history of misuse of the drug, even though they acknowledged the clinical evidence of acute dyskinesia (a medication side-effect for which anticholinergic medication is prescribed). Ellen reported that, once having been scheduled as mentally ill, she was treated as if had also lost her intelligence, and was subsequently excluded from decisions about her treatment.

Participants reported they did not discuss these perceptions of stigmatising treatment directly with clinicians. They cited the primary reason for this reluctance was the power imbalance between clinicians and people who live with mental illness. This imbalance is not restricted to the power granted to clinicians through legislation to detain and treat people coercively if they meet certain criteria, though this power had been utilised in the lives of nine out of the ten participants.

The power imbalance in the historical practice of psychiatry has been documented by Foucault (1980). Slade (2009) noted that this imbalance persists in current clinical practice in the relative weight given to knowledge held by people who live with mental illness and clinicians in consultations concerning treatment decisions. The imbalance also influences current research paradigms which privilege positivist models of knowledge over evidence from the lived experience of people who live with mental illness (Slade, 2009).

Goffman (1963, p. 76) identified a specific exercise of power that he termed ‘phantom acceptance’. Shirley’s reported experience with her treating psychiatrist illustrated this concept. Her psychiatrist supported her engagement as a consumer advocate, and displayed a health promotion brochure Shirley had co-authored in the clinic waiting room, granting recognition to her advocacy work, or ‘phantom normalcy’ (Goffman 1963, p. 76). However, when Shirley requested that her psychiatrist implement the intervention in her own health care, this was dismissed with the phrase ‘I don’t have time’. The support for Shirley’s collaborative initiative was performed in public, but disallowed within the private therapeutic engagement, revealing the ‘acceptance’ as ‘phantom’.

The psychiatrist’s reported refusal to provide the requested care was not explicitly stated as a refusal, but expressed metonymically as ‘I don’t have time’, where time is made to stand for intent. This is an example of how metonymic under-specification is strategically used (Littlemore 2015). A request is refused but the substitution of time for intent allows the speaker to deny that refusal is the intended inference, in turn creating the suggestion that any perceived slight is imagined (Goffman 1963). Eggins and Slade (1997) have pointed out a similar role for humour in workplace conversations, where humour can be used to form an in-group whose members can share jokes that isolate others, but subsequently deny this intent if it is explicitly questioned.

Participants also reported poor access to physical health care once their mental illness is disclosed, which they experienced as stigmatising. Shirley used the term ‘*diagnostic overshadowing’* to report her experience of poor treatment by a triage nurse in an emergency department. This term was used in a study in which emergency department clinicians reported multiple cases of misdiagnosis or delayed evaluation and treatment of people who live with mental illness (Shefer et al. 2014).This process has been reported by people who live with mental illness accessing emergency departments throughout Australia (Australian Commission on Safety and Quality in Health Care 2014).

Such treatment can reflect the problem of stigmatising attitudes held by clinicians toward people who live with mental illness (Ross & Goldner 2009). When these attitudes result in the delivery of sub-optimal care, the function of stigma has moved from prejudice to discrimination (Thornicroft et al. 2007). Goffman (1963) described how identification of a stigmatising attribute in a person enabled ‘normals’ to ignore any claims the person may make based on other attributes. This can be extended to include claims for comprehensive health assessment and care. Hill (2010) has reported on neurological evidence of reactions of moral repugnance by clinicians, but also demonstrated that these deeply felt reactions are amenable to change with training and support.

OTHER METONYMIC INFLUENCES ON THE EXPERIENCE OF TREATMENT

Experiences of sub-optimal treatment were not always perceived to be motivated by stigma from health workers. Participants reported experiences that were indicative of partial attention rather than prejudice. Shirley observed that the devastating effects of the depressive phases of bipolar disorder were frequently overlooked by health workers, who focused instead on people’s presentation in manic states, when they were ‘*bothering the public’*. Ethan, Nathan and Oliver all reported the experience of their diagnosis not being clearly explained to them, even as treatment based on that diagnosis was being initiated. They reported experiencing this clinical reticence as more disturbing than receiving the diagnosis.

These accounts echo similar experiences reported by participants in Barham and Hayward’s (1991) study, conducted over 20 years ago. The authors observed that:

> Many of our participants described how they received little or no guidance in tackling the meanings of schizophrenia, and were left to cope with the cultural burden of the diagnosis as best they could (Barham & Hayward 1991, p. 21).

They are also consistent with contemporary data collected in the *Obsessive Hope Disorder* report, where 20% of their respondents indicated that diagnosis was not discussed by their treating teams (Mendoza et al. 2013), and in a study by Cleary and colleagues (2010) in which 76% of the respondents rated being provided with a diagnosis as ‘very important’. The confusion that people are left with when clinicians do not provide clear information was also reported in the Scottish Recovery Network project:

> Some narrators felt let down by the professional services delivering their diagnoses. They felt that diagnoses were sometimes suppressed by professionals only to be given at a later date without information or support leaving them to feel disempowered about their own health (Brown & Kandirikirira 2007, p. 24).

While this process can be seen to be different from metonymic over-determination, it stems from a similar conceptualisation of the person, by dint of their diagnosis, not having capacity to participate in treatment decisions. In cognitive linguistic terms, this is effectively a combination of metonymy with ellipsis (Al-Sharafi 2004); clinicians metonymically deduce that the person lacks capacity to cope with the diagnosis of mental illness, and so they elide reference to this in their discussions.

An explanation stems from the way in which clinicians routinely practise cognitive shorthand in making assessments, selecting what they view as salient information. Making a diagnosis involves trained use of focus, and setting aside extraneous elements. Oliver commented that in his experience, this process was hastened by resource issues. If a person’s history of mental illness is selected as the salient element, a clinician may focus on this, and miss, or defer attention to other elements. This is not necessarily a question of stigma, but of the cognitive operation of attention, where foregrounding of an element necessarily forces other possible elements into the background (Talmy 2007). James (1890/1950) noted how attending to one attribute involves ignoring other available evidence. Problems arise when this practice entails habitual foregrounding or backgrounding of mental illness, rather than clear focus on the current presenting problem. Patel and colleagues (2015) have investigated the role of cognition in both error generation and error recovery in health care, and suggested ways in which this knowledge can be used to improve safety. Metonymy is a cognitive process that frequently goes unremarked yet, as participants’ narratives demonstrated, can be just such a source of cognitive error.

While inattention can be explained cognitively, there is also evidence that some clinicians deliberately avoid responding to patient’s cues, particularly when these are emotional in nature (Uitterhoeve et al. 2009), or expressed in figurative language. Lancely and Clark (2013) observed the practice of some nurses who responded effectively to the emotional needs of people in treatment for cancer, but others who evaded this engagement, seemingly ‘excused’ by the fact that people often expressed their fears in metaphoric terms, which the nurse could claim not to have understood.

This aligns with participants' reports of believing clinicians were too frightened to talk to them about their experience.

Participants reported experiencing clinicians underestimating their capacity to make decisions once they had been diagnosed with mental illness, or made involuntary patients under mental health legislation. These practices have been addressed in changes introduced into the two most recently amended mental health acts (Mental Health Act (Victoria) 2014; Mental Health Act (Western Australia) 2014), which include provisions requiring clinicians to demonstrate they have assessed the person's capacity to give informed consent before every treatment decision.

The influence of metonymy is also evident in participants' reports of good experiences of treatment. Participants reported on the positive influence of careful language choices by clinicians, in particular, language that positioned both the person providing and the person receiving care as people engaged in communication. They also noted the beneficial effect when clinicians used unfamiliar language such as psychiatric diagnoses carefully, ensured the person receiving the information understood, and were open about what they were thinking in terms of the relation of participants' reported experiences to possible diagnoses. These are the kinds of practices identified in a recent qualitative study published on the topic of the needs of people receiving serious mental health diagnoses (Milton & Mullan 2014). This study noted that people wanted information at the time of diagnosis, but wanted that information to be tailored to their individual understanding. It also noted that individuals wanted assistance to manage their own self-stigmatising ideas, based on previous misconceptions of mental illness. Commenting on how this is handled, one of their participants observed, "Some [clinicians] would treat the illness, some would treat the person, and the ones that treated the person would have better outcomes" (Milton & Mullan 2014, p. 462). This reiterates the concept that metonymically foregrounding the person before the diagnosis contributes to better treatment.

Participants' narratives in the current study further suggested that it is not just people who live with mental illness who are viewed as constrained by their position in the encounter, but that health workers can be equally constrained by their roles. They described positive encounters with clinicians, but these were presented as outside their expectations. This indicates a mismatch between contemporary portrayals of holistic practice, and people's actual experience of care. Peplau (1952/1988, p. 70) addressed the possibility of therapeutic interactions benefiting both participants fifty years ago:

> Nurses often symbolize nonrational roles to patients, that is, they stand for but are not mothers of patients, and they take on these roles at the same time helping the patient to clarify his preconceptions and to become aware of the nurse as a person in her own right.

The symbolic role Peplau (1952/1988) posits for nurses is metonymic; they 'stand for' but are not the patients mothers, and in performing this role for the patient, they are also enacting selfhood for themselves. Walker (1994, p. 165) has suggested that narrative contributes to this work:

> Nurses lives then, can be theorized as being inextricably woven out of narrative structures which work to impart coherence and order…on the 'rough and tumble' of everyday life in practice.

This underlines the idea that nurses have a need to make meaning of their experiences in therapeutic encounters as well as the people they care for. Following Menzies Lyth (1959/1988), this kind of nursing can only occur within a health care system that enables the opportunity for workers and people receiving care to form therapeutic attachments. Participants reported their experience of considerable benefits when they encountered therapeutic engagement, and confusion and increased distress when it was absent.

METONYMY AND THE EXPERIENCE OF SYMPTOMS

Metonymy, as both a conceptual and a linguistic process, influenced participants' accounts of their experience of symptoms. They reported delusional beliefs that demonstrated inferences linked to metonymic sources. In some cases, the metonymic link between a sign and the inference drawn from it was relatively straightforward. Nathan inferred that he was expected to die soon when he was placed in hospital near old people. Ian's guilt about illicit substance use was manifested by experiencing a voice telling him he was going to go to hell. Shirley's description of London as, '*quite a good place to sort of flip out, because everything actually is sort of connected',* highlights the fact that the capacity to infer specific meanings from locations is available to anyone. The development of other reported delusions involved a further meaning-making step. Ethan's real sense of powerlessness was transferred into the belief he was a political prisoner. Shirley's fear of harm coming to those close to her was tied to the tension she experienced as an identified critic of drug companies. These can be seen as examples of metonymic chaining (Brdar-Szabo & Brdar 2011).

These reports align with the work of Rhodes and Jakes (2004), psychologists who suggested a metonymic motivation for a delusion reported by a study participant with schizophrenia. Their suggestion was subsequently taken up by the cognitive linguist Littlemore (2015), who identified further potential metonymically motivated delusions in Rhodes and Jakes (2004) original data set. In both cases, the metonymic links the authors draw are conceptual and not linguistic. Similarly, the cognitive links in the participants' narratives are between signs perceived in the world and internal inferences they subsequently draw. This is different to inferences being drawn through the use of metonymic language, as often the links have not yet been expressed linguistically.

With the research methods currently available, theories about possible metonymic motivation for delusional beliefs cannot be confirmed. This is consistent with the inexact nature of following thought patterns, which Hobbes (1650/2011) described. Psycholinguists have used neuroimaging techniques to track the activation of specific brain regions during language performance, in order to identify correlations between brain activity and clinically demonstrated thought disorder, but they concede that their findings, though suggestive, remain speculative (Kuperberg, Kreher & Ditman 2009). Empirically, the participants in the current study were unable to confirm metonymic motivations for delusional beliefs with any more certainty than the researcher.

The reporting of symptoms is a key point of intersection between the two research questions in the current study. Descriptions of delusional beliefs suggest the influence of metonymy, in its conceptual sense, on the experience of people who live with mental illness. However, these experiences are not necessarily expressed in metonymic language. Conversely, when describing symptoms more broadly, including symptoms such as hallucinations that are not linked to conceptual metonymy, participants used a range of language practices, including figurative language, in order to report experiences that they described as difficult to convey. Thus, the influence of metonymy in their speech production was tied to their capacity to give voice to their experiences.

When asked how he described his symptoms, Nathan chose to use the exact clinical diagnosis he had been given in order to describe his experience, '*depression with psychotic features*'. Tanya reported using different terms depending on the context in which she was talking, though she inverted the usual order, using 'schizophrenia' with acquaintances, but less specific terms such as 'mental illness' when conferring with clinicians. Michael used metaphor and metonymy, describing the '*noise musicians*' inside his head. Shirley and Ian described how difficult it is to articulate the experience of symptoms. Ethan used the metaphor ‘*descent*’.

The metaphor of mental illness as ‘descent’ was a concept given currency by the work of R.D Laing (1960) and other early psychiatrists who were active in the ‘anti-psychiatry’ movement in the 1970s, most notably given first-person voice by Mary Barnes (1971). There are parallels with the frequently figurative terms used in clinical discourse, such as ‘flight of ideas’ (Akiskal 2009), which serves as an antonym for descent. The cognitive links between the metaphoric term and the embodied experience of negative emotions have been described by cognitive linguists (Kovecses 2006; Lakoff 1987), who have noted the bodily experiences such as lethargy and drooping posture that align with, and possibly underpin the concept of depression as descent.

Participants used metaphor when they were describing their experience of psychosis. In response to their sense of the ineffability of the experience, they spoke of what it was like, rather than what it actually was. In contrast, when speaking of the functional and pragmatic effects of the illness in general, participants strategically used metonymic language to mark what it ‘stood for’ in their lives. Thus, Michael reported that ‘*“recovery from schizophrenia” sounds much nicer’* [than schizophrenia]. Shirley spoke of limiting the conceptual power of psychosis by referring to it as ‘*scary thoughts’* and reported this had a pragmatic effect in her recovery from her most recent psychotic episode. Michael was thus exploiting the foregrounding aspect of metonymy (Talmy 2007), highlighting the recovery over the diagnosis while keeping both visible. Shirley was using the ‘stand for’ aspect (Feyaerts 2000), displacing the clinical ‘psychosis’ with the more quotidian ‘scary thoughts’, using indirect reference to render the experience more manageable. Participants’ use of metonymic language is explored further in the following section.

The influence of metonymy on the speech production and speech comprehension of people who live with mental illness

The answer to the second research question, ‘How does metonymy influence the speech production and speech comprehension of people who live with mental illness?’ comes in two parts. In the first instance, there was some evidence of problems in the production and comprehension of metonymic language. While the speech production of participants minimally evinced unusual word choices, consistent with the ‘metonymic speech' identified by earlier researchers (Cameron 1944; Goldstein 1944), participants did demonstrate and report difficulties with comprehension of speech, particularly figurative speech, in line with earlier research findings (see, e.g. Chapman 1960; Kuperberg, Kreher & Ditman 2009).

In the second instance, participants demonstrated the capacity to both produce metonymic references, and accurately process metonymic inferences spoken by others, consistent with cognitive linguistic understanding of the ubiquity of the figure in everyday speech (Lakoff 1987; Littlemore 2015).

METONYMIC SPEECH

I detected rare examples in participants' narratives of the obscure indirect referencing defined as metonymic speech by Cameron (1944) with Tanya's reference to '*the lion-head pond'* being the most idiosyncratic and potentially opaque example. This finding is consistent with studies by Andreasen and colleagues (Andreasen 1979a; Andreasen & Grove 1986), that included metonymy under the term 'word approximations', but uncovered little evidence of its use in their data. It can be interpreted in light of three issues. First, Cameron's studies (1938; 1944) were undertaken prior to the discovery of anti-psychotic medications, and so the people with mental illness that he engaged with remained in psychotic states for longer periods than is common today, potentially leading to more acutely disordered language production. Second, the way that metonymy is conceived has undergone significant changes in the last 70 years, from being restricted to a figure of rhetoric to being understood as contributing to the way in which experience is cognitively understood and communicated (Lakoff & Johnson 1980; Littlemore 2015). This has led to broader recognition of the operation of metonymic inferencing. Third, data in this study were collected through narrative interviews and so participants had control of the context they established; as the researcher, I was primed to infer the salient meanings for terms by the preceding content of their stories, and therefore less likely to capture the kind of irregularities noted in previous context-free studies.

COMPREHENSION OF METONYMY

Participants demonstrated or reported difficulties in speech comprehension in relation to the meaning of words, particularly when these meanings changed in different contexts. Michael's remark that, '*often I'm caught out, because in this short period something's changed, and I haven't really kept up with the change'* resonates with Cameron's description of trying to understand one of his research participants: 'One goes along for a bit all right, but then begins to slip behind and miss the meaning' (Cameron 1944, p. 54).

Responses to the 'quick quiz' question, '*Would you like another glass?*' demonstrated the range of influence metonymy has on the experience of people who live with mental illness. For the majority, processing the intended non-literal meaning, that is, the contents of the glass rather than the container itself, posed no problem. While the 'quick quiz' revealed comprehension difficulties for some participants, it also evinced others' capacity to chain metonymies together, to infer meaning that may be prompted by context, but incorporated world knowledge external to language (Brdar & Brdar-Szabo 2003). This was best captured in Shirley's response, '*Well, I'd be thinking Chardonnay'.*

It was the intensity with which the ambiguity of the non-literal request was noted that distinguishes the responses of participants. Michael responded with tangentiality, talking about his ideas about language in place of answering the question. Ethan inferred a threat from the possibility that the glass be used to 'glass' someone, suggesting an atypical inferential schema consistent with paranoid ideation, but also the activation of mental concepts through semantic priming (Kuperberg & Caplan 2003). Even more pronounced was the disturbance experienced by Matthew in response to not being able to comprehend the intended inference of the question, accompanied by the social unease engendered by this inability.

These findings are evidence of the language comprehension challenges faced by some people with mental illness, and previously observed by researchers (Chapman 1960; Kuperberg & Caplan 2003). Participants reported on the impact of these communication difficulties. Michael and Tanya each spontaneously reported that they have simply stopped talking at times, and others reported situations where they have been reluctant to engage in social interactions because of the concerns in relation to their capacity to communicate.

The issue of people not talking has broader implications, as Goffman (1963) flagged. If people with lived experience of mental health issues stop talking, not because they want to, but because they cannot keep up with conventional conversational practices, this increases their social isolation and inhibits their interactions with others. These elements can lead to further deterioration in their social functioning and mental state (Bowie & Harvey 2008). Moreover, the contribution they can make to community and social life is lost (Barham & Hayward 1991).

LINGUISTIC AND CONCEPTUAL METONYMY IN PARTICIPANTS' 'EVERYDAY' LANGUAGE

The study provides information about the overall use of language by people who live with mental illness, rather than just evidence of impaired use. As members of the broader speech community, participants demonstrated capacity to produce and comprehend metonymic speech, both in their own free narratives, and in response to questions from the interviewer. Metonymy appeared in combination with other figurative language in blends and idioms, in phrases that are so common their metonymic origin is hard to discern, and in novel and original ways.

Participants demonstrated sophisticated skills in using metonymic language to create intended inferences. Oliver combined ellipsis and metonymy (Al-Sharafi 2004) to report his dissatisfaction with the care he received, while graciously avoiding attributing blame to specific individuals. Ian used a metonymic reference, '*the boys would be there',* to counter an initial joking question as to whether he was a gelding when he recounted a story of imagining himself as a prize-winning horse. Veale, Feyaerts and Brone (2006) have demonstrated how metonymy facilitates this style of humour, as the speaker can show they have understood another's inference, and 'trump' it, by using a further indirect reference. Shirley's strategic use of the metonymic '*pen on the prescriber's pad*' demonstrated adept use of media-friendly, readily inferred language, consistent with the renewed interested in metonymy's effectiveness in the rhetorical practice of persuasion (Littlemore 2015). Each of these examples showed that participants exercised these linguistic skills in the performance of social interactions: Oliver allowed others to save face; Ian bonded with a stranger through humour and Shirley exploited the constraints imposed by media to represent clinical accountability.

Rochester and Martin (1979, p. 24) identified a problem with the traditional approach to research on language use by people who live with mental illness:

> The aim has been to capture, not the distributional properties of the corpus, but its deviant features. That is, rather than describing the utterances as a whole, investigators of schizophrenic speech have attempted to characterize those features of the corpus that differ from normal. In effect, the effort has been to describe the failures rather than the overall performance of the schizophrenic speaker.

This focus characterises the contemporary approach taken by psycholinguists, as they themselves note (Kuperberg & Caplan 2003). By presenting the full breadth of participants' experience of metonymic and pragmatic inferencing, the current study contributes to broadening our understanding of language as it is experienced by people who live with mental illness.

NARRATIVE

The initial interviews with participants sought to elicit their narratives in their own words. Participants deployed a significant range of narrative skills. Ian and Ellen were adept at embedding smaller narratives within larger ones. Tanya's narrative included the occasional unprompted insertion of heavily detailed vignettes. Michael engaged in discursive play with the narrative metaphors of journey and myth. Shirley, who has narrated her experience to a variety of audiences, used the term '*patient porn'* to describe a particular relation between the story of the person who lives with mental illness and the story's consumption by others. Ethan described the ongoing evolution of his story and the contribution of this to his recovery.

Oliver, Ellen, Stan and Shirley frequently combined reported speech and direct speech in their narratives of past experiences, even when it was not feasible that they could recall exact words used in conversations held years ago. In literary terms, such a practice constructs verisimilitude, that is, it creates the appearance of a 'true' narrating of the episode (Bruner 1997). The 'unreliable narrator' (Lodge 1992) has been a trope in literature long before qualitative researchers cautioned against taking informant's words completely at face-value (Hammersley 2008). This is not to say that participants are being deliberately misleading when they adopt such techniques in telling their stories. Rather, it is to recognise that they utilise conventionalised strategies to create meaning.

Michael's account of coming to the recognition that he had a mental illness in the midst of his tenth involuntary hospitalisation is an example of another narrative technique, beginning a story *in media res*, that is, in the middle of the action, with the beginning not explained. This was an example of a participant's narrative extending beyond the straightforward chronological order identified in traditional narrative models (Labov & Waletzky 1967/1997).

Narrative as a metaphor for life underpins narrative practice (White 2007). Moreover, some of the strategies participants adopted in reconstructing their experiences in narrative were metonymic, with specific elements of their past selected for foregrounding. James (1890/1950, p. 571) observed:

> In no revival of a past experience are all the items of our thought equally operative in determining what the next thought shall be. Always some ingredient is prepotent over the rest. Its special suggestions or associations in this case will often be different from those which it has in common with the whole group of items; and its tendency to awaken these outlying associates will deflect the path of our revery. Just as in the original sensible experience our attention focalized itself upon a few of the impressions of the scene before us, so here in the reproduction of those impressions an equal partiality is shown, and some items are emphasized above the rest. What these items shall be is, in most cases of spontaneous revery, hard to determine beforehand.

At times, eliding certain events was a deliberate choice, with participants collaborating with the interviewer to foreclose discussion of traumatic events. However, in line with James (1890/1950), participants frequently demonstrated spontaneous shifts mid-narrative, as they recalled and recounted events prompted by the act of narrating itself.

Running counter to the frequent indeterminacy of both narrative and memory is a broad cultural constraint on people to provide coherent accounts of themselves: ‘Those who are in a strict sense not capable of biographically presenting themselves create interactional disturbances’ (Fischer-Rosenthal 2000, p. 116). This narrative demand accompanies a pressure to present a coherent self to others. It is arguable whether the demand extends to actually having a coherent self, but certainly people are subject to, and aware of an implicit demand to maintain a coherent, contained self in their interactions with others. This also links to the issue of visibility addressed earlier in the chapter.

Ethan reported that the act of narrating provided cohesion to his sense of his experience. This echoes Stuhlmiller’s (2001, p. 65) concept of narrative as an organising process:

> Not only do narratives metaphorically create categories for interpreting events, but also they bind people and events into some intelligible pattern.

Stuhlmiller (2001) highlights how the metaphor of life as a narrative supports its use as a strategy for meaning-making. For Ethan, who described the experience of mental illness as ‘*disintegration*’, it is the capacity of narrative to ‘bind events… into some intelligible pattern’ (Stuhlmiller 2001, p. 65) that enables him to view his life as other than ‘*a slag heap*’. The structuring of his life in narrative terms initially creates a sense of cohesion in relation to his experience. Communicating this narrative in turn contributes to rendering the experience of mental illness intelligible to other people. In a third, recursive step, the ‘evolving’ retelling in turn builds the narrative that sustains him in his recovery. This ongoing process enacts the therapeutic effect of narrative practice (White 2007) in its purest form, dispensing with the therapist entirely.

Shirley’s use of the term ‘*patient porn’* draws on a contemporary critique of the potentially co-optive uses of the personal narratives of people who live with mental illness by mental health services and researchers (Costa et al. 2012). In light of this, and echoing Ethan’s invocation of the transforming power of narrative, she reported that she deliberately used the constraining form of the narrative interview requested within the current study to explore aspects of her own experience that she had not previously disclosed.

Contribution to cognitive linguistics

While not explicitly setting out to do so, the study contributes to the literature on cognitive linguistics. Cognitive linguistics has been criticised as relying too much on examples that are constructed by researchers, rather than drawn from actual speech (Gibbs 2007b). This study contributes to the recent development of ‘corpus-based’ cognitive linguistic research, using examples of actual speech to understand the cognitive processes occurring. Whereas many of these corpus studies draw on existing bodies of language (see, e.g. Markert & Nissim 2003), this study constructs a new body of data, 400 pages of narrative interviews with people who live with mental illness.

From a cognitive linguistic perspective the results of the study demonstrate that people with serious mental illness have the capacity to both construct and interpret sophisticated figurative language in online speech. It demonstrates that while participants do indeed produce metonymic speech, this is consistent with conceptual metonymy as described by cognitive linguists (Lakoff & Johnson 1980; Littlemore 2015) rather than the ‘metonymic distortion’ identified by psychiatrists early in the twentieth century (Cameron 1944; Goldstein 1944). It also demonstrates that some participants experience difficulties in comprehending figurative language, consistent with findings reported by earlier researchers of research participants being unable to follow shifts in inferences attached to words used in specific contexts (Chapman 1960; Rochester & Martin 1979). This is linked to the cognitive linguistic principle that words trigger an encyclopaedic response rather than a dictionary one (Langacker 2007). Ironically, Michael explicitly invoked this concept when asked if he sometimes missed other people’s meanings in conversation, *‘Well, that’s what the dictionary’s for’*.

Littlemore (2015) has suggested that greater attention to metonymy may improve the teaching of English as a second language, psychotherapy, and political discourse, through recognition of the inferences that are created, intentionally or otherwise, by the use of metonymic ‘hidden shortcuts’. The current study suggests that clarifying the influence of metonymic pragmatic inferences in the language they encounter may improve the experience of people who live with mental illness.

Limitations of the study

This is a qualitative, descriptive study, designed to explore the experience of language of people who live with mental illness. Analysis of the use of language is observational and descriptive. As noted, every person’s language evinces different characteristic patterns (Jakobson 1956/1987). The study does not provide analysis of the language use of a comparison group of people who do not have diagnoses of mental illness. As someone who has worked as a mental health nurse for more than fifteen years, it is possible that long-term interaction has reduced my capacity to notice speech produced by people with mental illness as unusual.

The study method included interviews which were audio recorded and transcribed. Subsequent analysis was restricted to analysis of the text of the interviews. Andreasen (1979a) has observed that non-verbal data can be lost in such a process, and suggested that combining audio recording with video recording may attenuate this loss, without however, outlining how these data could be analysed. The analysis in this study is limited to transcripts of audio recordings. While some notations were made, including significant pauses, laughter, and gestures used intentionally to suggest meanings (pointing at the recording device, circling arms around head), there is not an analysis of non-verbal communication. This is for a number of reasons. The research explicitly addresses the creation of meaning and inference through language, and therefore it is appropriate to consider participants’ language. There are reliable methods for analysing language as text, and text remains available for interested parties to refer to, to check analytic decisions.

There was a potential for self-selection bias among the participants, that is, only participants who had an interest in language would agree to participate in the study. A number of participants did express significant interest in language, both language use in general, and language use around mental illness in particular. For a number of participants, this interest is professional, as they are people whose work life has involved language practices including narration or ‘story-telling’, writing and training.

All participants were currently taking medication. Anti-psychotic medication and other neuroleptics, including mood-stabilising medications, have side-effects which include influencing cognition. At a basic level, people can experience some sedation, and also a slowing of the speed of their thought processes. This may in turn make changes to the information collected in interviews. The aim of the study was to explore the influence of language on the experience of people who live with mental illness, rather than language during acute psychotic episodes, and most of the participants credited medication as a significant factor in their recovery. Therefore it made sense to interview people in the recovery phase, incorporating the potential effects of prescribed medications.

Implications for further research

This study has investigated the influence of metonymy on the experience of people who live with mental illness, using their narratives and language, but reported from the perspective of a single researcher with a background in mental health nursing and policy. The practice of co-research (Speedy 2005), where investigators and participants work together as partners rather than researcher and research subjects, is gaining momentum in the mental health context (Costa et al. 2012). This approach would potentially be effective for further research exploring the construction and negotiation of meaning and inference, which is necessarily a joint process.

The current study included information about how people who live with mental illness experience the language used by mental health workers. Complementary research could investigate mental health workers' thoughts about the strategic use of diagnostic language, their understanding of the complexities differentiating all language users from each other, and their observations of the influence of the language they use with people who consult them.

Cross-language research in cognitive linguistics has revealed that there are some similarities and some differences in use and interpretation of figurative language in different languages (Brdar-Szabo & Brdar 2012; Radden & Seto 2003). The limited research on the experience of people from culturally and linguistically diverse backgrounds who live with mental illness indicates that they experience greater difficulties in their communications with mental health workers (Minas et al. 2013). Research that mapped the influence of metonymy across languages in the mental health context may help to address these issues.

Participants reported that some of the most effective encounters they have had have been with other people who live with mental illness. Beyond the benefits of support, they have identified the sharing of specific techniques is effective in their own management of their experience. The research on peer support workers has been criticised as not providing rigorous enough evidence (Lloyd-Evans et al. 2014). Notwithstanding this concern, the employment of peer support workers, both as direct service providers, but also as trainers for undergraduate and existing practitioners is increasing (Repper & Carter 2011). Reflecting participants' views on what actually works for them, consideration may be given to research that navigates between establishing rigour and supporting innovation in this area.

The current study did not produce evidence about the effectiveness of explicitly drawing attention to metonymic language and thinking in therapeutic work, though this approach formed part of my previous clinical work. The study has demonstrated the prevalence and influence of metonymy on people's experience. Participants demonstrated sophisticated understanding of language they encountered, and competency in using language themselves. When metonymic links were made explicit by the researcher, participants frequently expressed that they grasped the ideas, and could trace their influence on their thinking. In doing this, they also demonstrated recognition of how metonymic concepts underpin significant topics of concern, such as identity and stigma, opening the possibility of exploring its therapeutic potential in future research.

Implications for practice

Participants reported encountering stigma from health workers. They reported that stigma was conveyed through language, through attitude, and also through the delivery of sub-optimal care, for both mental and physical problems. Stigma against people who live with mental illness has been a subject of concern for more than fifty years (Goffman 1963), yet it persists (Hill 2010; Reavley & Jorm 2011; Ross & Goldner 2009), with participants reporting stigma-related actions by health workers occurring from the 1970s through to 2014. This study supports the call of Thornicroft and colleagues (2007) for attention to shift to acts of discrimination rather than further surveys of attitudes. Health service organisations have responsibilities under governance standards to ensure services are provided to all without discrimination (Australian Commission on Safety and Quality in Health Care 2014), and could use performance management systems, supported by education and adequate resources, to enable health workers to provide health care without stigma to people who live with mental illness.

Participants reported encounters with mental health workers that were not stigmatising, but nonetheless frustrating. These were frequently related to language. Influential resources used in making diagnoses (American Psychiatric Association 2013), and preparing people to work in mental health (Sadock 2009), present limited views of communication, with the person's language subject to scrutiny, but the health worker's presumed to be transparent and effective. This is not consistent with participants' reports of their communications with health workers. Encouragement for clinicians to understand their own cognitive and communicative processes is likely to improve the experience of the people they encounter, and the safety of the care that is delivered (Patel, Kannampallil & Shortliffe 2015). Following Zola (1993) and others, clinicians have learned to refer to people without nominalising the diagnosis, and following Vygotsky's theory of knowledge development, the subsequent 'zone of proximal development' (1978, p. 86), would be to develop understanding of the concepts underpinning this language use. Recommendations for closer attention to the actual language used by people have been made by nurses (Lanceley & Clark 2013; Peplau 1952/1988; Stein-Parbury 2014), psychiatrists (Lewis, Escalona & Keith 2009; Meares 2005), narrative therapists (Jenkins 1990; White 2007; White & Epston 1990), researchers (Rochester & Martin 1979; Wengraf 2001) and linguists (Littlemore 2015; Verschueren 2009). The mapping of metonymy's influence from cognitive linguistics to the experience of people who live with mental illness that is presented in this study can contribute to this development.

The study supports the facilitation of people who live with mental illness engaging with each other. This does not happen automatically, but requires support and facilitation, as the participants in Barham and Hayward's (1991) study confirmed. Participants in the current study reported that engagement with peers was among the most helpful factors in their recovery. They reported the pragmatic benefits of the knowledge exchanged in these encounters, including how to manage the impact of psychosis by strategically using metonymic language to describe and conceptually contain it.

Finally, increased community awareness of communicative competency across different language abilities may contribute to expanding social networks, so that people whose social intent is in fact inclusive are not unwittingly practising social exclusion toward people who live with mental illness. Programs such as SANE's StigmaWatch

(SANE Australia n.d.) can contribute, not simply through monitoring and educating media, but by engaging the community in attending to the power of representations.

Conclusion

This study explored the influence of metonymy and pragmatic inferencing on the experience of people who live with mental illness. The findings demonstrated that the two research questions intersect, as the influence of metonymy on the speech production and comprehension of people who live with mental illness has an impact on the broader influence of metonymy in their experience, including how they give voice to that experience.

The study collected data from people living with mental illness about their experience of language in clinical and other settings, in their own words. It thus adds to knowledge, beyond diagnostic or experimental results, information about people's experience of language in everyday life, and in their contact with the services designed to help them.

The study demonstrated that metonymy influences the everyday language of people who live with mental illness, consistent with their membership of the broader speech community. This contributes information about language use by a specific population to the cognitive linguistic field.

The study further demonstrated that metonymic inferences carry specific significance in the experience of people who live with mental illness. Inferences drawn about the people who live with mental illness can inform clinical treatment including diagnosis, and the subsequent delivery or withholding of care. Diagnoses in turn metonymically influence the experiences of identity and stigma.

These inferences can be determined by metonymy operating conceptually or linguistically, consciously or unconsciously, by people themselves, or by the people they interact with, including clinicians. Each of these can be influenced by knowledge and perceptions about the world, or meaning conveyed through the medium of language.

In each instance of metonymy, options arise. Meaning can be conveyed literally instead of indirectly. Inferences can be drawn that are not intended. Negative inferences can be deliberately intended, but disavowed, creating uncertainty. Attributes can be deemed salient and foregrounded, leading to efficiency on the one hand, but potential mishaps on the other. It is neither possible, nor desirable, to reduce the influence of metonymy. However, this study demonstrates that greater attendance to this influence has the potential to improve the experience of people who live with mental illness.

The study demonstrated that participants themselves already express acute awareness of the language they experience, and the influence of this on their own experience. In response, they have developed sophisticated strategies in their own language use to address these influences, contesting practices that hinder, and supporting and reinforcing those that help.

APPENDICES

Appendix A: Information for participants

UNIVERSITY OF
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A Study of Metonymy in the Language of Mental Health Nursing

Information for Participants

Introduction

You are invited to take part in a research study into language use in communication about mental health, because of your experience of living with a mental health problem, and/or working with people with mental health problems.

Metonymy is the name for what we do when we call something by a word closely related to the actual word, selecting an attribute of the thing to stand for the whole thing. For example, if we say ‘give me a hand’ we are not literally asking for just one body part, but for help from the whole person. Frequently, selected attributes are taken to mean more about people than just the thing named. If we know a nurse is married to an engineer, we are likely to think the nurse is female and the engineer male, based on their occupations. Similarly, a person can be spoken of in terms of an illness they have: ‘an asthmatic’ or ‘a schizophrenic’.

This study is being conducted by Andrew Moors, a PhD student in the Faculty of Nursing Midwifery and Health at the University of Technology, Sydney. He is being supervised by Professor Jane Stein-Parbury, of the University of Technology, Sydney.

Study Procedures

If you agree to participate in this study, you will be asked to sign the Participant Consent Form. You will then be asked to agree to participate in two interviews, conducted approximately a month apart. In the first interview you will be asked to tell a story about your experience, and in the second interview you will be asked questions based on elements from your own story.

These interviews will be digitally audio recorded. These recordings will then be transcribed word for word, with any information that may identify individuals removed. The language used will then be analysed. The transcripts with no identifying material will be stored in password-protected computers, and a locked filing cabinet, and only the researcher and his supervisors will have access to them.

Risks

Participation in this study should carry minimal risks for you. You may feel inhibited in what you say because you are aware it is being recorded, or you may feel afterwards that you wish you hadn't said something in a certain way.

If you feel any discomfort, you can discuss this with Andrew Moors, or with your regular treating clinicians.

You can ask to have your contributions erased from the record, before or during data analysis, however once study results are published this would not be possible.

Benefits

While it is intended that this research study furthers knowledge about effective communication about mental health issues, it may not be of direct benefit to you.

Costs

Participation in this study will not cost you anything, nor will you be paid.

Voluntary Participation

Participation in this study is entirely voluntary. You do not have to take part in it. If you do take part, you can withdraw at any time without having to give a reason. Whatever your decision, please be assured that it will not affect your treatment, or your relationship with the staff who are caring for you.

Confidentiality

All the information collected from you for the study will be treated confidentially, and only the researcher named above, and his supervisors, will have access to it. The study results may be presented at a conference, in a thesis submitted for a Doctor of Philosophy at the University of Technology, Sydney, or in a scientific publication, but individual participants will not be identifiable in such a presentation.

Feedback to participants

A plain language summary of results will be available from the researcher at the completion of the project which can be sent to you electronically via email or through the post. If you would like to have a copy sent to you please provide Andrew Moors with an email or postal address. These contact details will not be linked to the data and will be destroyed once a summary has been sent out to you.

Further Information

When you have read this information, Andrew Moors will discuss it with you further, and answer any questions you may have. If you would like to know more at any stage, please feel free to contact him on 0400 84 22 66.

This information sheet is for you to keep.

Ethics Approval and Complaints

This study has been approved by the Ethics Review Committee (RPAH Zone) of the Sydney Local Health Network. Any person with concerns or complaints about the conduct of this study should contact the Executive Officer on 02 9515 6766 and quote protocol number X11-0031.

Appendix B: Recruitment information published on websites

UNIVERSITY OF
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Language and Psychosis

What is the research project about?

The aim of this research is to gain an understanding of the influence of language on people with lived experience of psychosis. In particular, I am looking at the language that gets used about people in different contexts, including therapeutic settings, and if this language leads to constraints on opportunities for recovery.

Who is doing the study?

My name is Andrew Moors. I am doing this research for a PhD in Nursing, supervised by Professor Jane Stein-Parbury in the UTS Faculty of Health. I have worked as a mental health nurse for seventeen years, and the research arises from my clinical work.

What does the study involve?

The research entails participation in two interviews, held a month apart, and each lasting between 30 to 60 minutes.

This research has been reviewed and approved by the Human Research Ethics Committees of UTS and Sydney Local Health District.

Who am I looking for?

I am seeking participants with lived experience of psychosis, with or without a diagnosis of schizophrenia, who would be comfortable telling their story, and then answering some questions about their experience.

Why participate?

This research is aimed at better understanding specific aspects of communication between people with lived experience of psychosis and others, including nurses, narrative therapists and other health professionals. I hope to contribute to the development of more effective therapeutic communications.

More information:

For further information about this study, please contact Andrew Moors at:
Andrew.J.Moors@student.uts.edu.au

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A Study of Metonymy in the Language of Mental Health Nursing

PARTICIPANT CONSENT FORM

I, ……………………………………………………………………………… [name]

of……………………………………………………………………………… [address]

Have read and understood the Information for Participants on the above named research study and have discussed the study with …………………………………

I have been made aware of the procedures involved in the study, including any known or expected inconvenience, risk, discomfort or potential side effect and of their implications as far as they are currently known by the researchers.

I understand that the interviews will be digitally audio recorded, and the recordings electronically archived, and I agree to this.

I freely choose to participate in this study and understand that I can withdraw at any time.

I also understand that the research study is strictly confidential.

I hereby agree to participate in this research study.

NAME: ………………………………………………………………..

SIGNATURE: ………………………………………………………………..

DATE: ………………………………………………………………..

NAME OF WITNESS: ………………………………………………………..

SIGNATURE OF WITNESS: ………………………………………………..

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